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**FINAL EVALUATION
OF
WORLD RELIEF CORPORATION'S
CHILD SURVIVAL PROJECT
AND THE
FIELD OPERATION IN BONNE FIN, HAITI
(EVANGELICAL BAPTIST MISSION IN SOUTHERN HAITI (MEBSH))**

**USAID-WRC
COOPERATIVE AGREEMENT
OTR-0536-A-00-7224-00**

JULY 1 - 17, 1991

Submitted by: Harry Godfrey, Public Health Consultant

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I. SUMMARIES

A. SUMMARY, MEBSH CHILD SURVIVAL PROJECT - 15 July 1991

In accordance with USAID guidelines for end-of-project evaluations, an independent public health consultant, assisted by staff of the World Relief Corporation (WRC) and the Evangelical Baptist Mission in southern Haiti (MEBSH), evaluated WRC's Child Survival (CS) Project. The team assessed WRC's headquarters performance in providing technical and financial oversight and support to their counterpart (MEBSH) in the field. The consultant and WRC staff member then went on to Haiti to join the previous director of MEBSH\CS to assess the effectiveness/impact of MEBSH's child survival services in the field.

The CS Cooperative Agreement between USAID and WRC was originally to be carried out between June 1, 1987, and May 30, 1990, but because of uncontrollable delays in starting (political instability, security problems, etc. for approximately one year) the project was extended through September 30, 1991.

The CS Project serves 26,000 people within a radius of 16 kms of MEBSH's Lumiere Hospital in Bonne Fin, Haiti. The four-plus year budget was U.S. \$331,900: \$249,400 from USAID and \$82,500 from WRC. A financial audit for the CS project is scheduled to follow this evaluation later on in July 1991.

Overall the project exhibited several strengths. It has made some significant gains during the original grant period as a majority of the project objectives were met. A solid infrastructure has been put in place that will carry CS initiatives in that region into the future, an excellent training program for health promoters and traditional birth attendants has been designed and implemented and a significant level of community participation has been generated through the program. During the upcoming expansion phase, project personnel will need to give attention to the recommendations of this evaluation in order to consolidate the gains achieved and build toward a more sustainable project.

MAJOR FINDINGS

Five auxiliary nurses and four community animators have been identified, trained and are working in the CS project. Nurses, in response to a 15 question test on technical aspects of vaccinations, dehydration, nutrition, vitamin-A and child spacing, answered correctly, on average, 96% of the questions. The animators answered, on average, 75% of seventeen questions on a similar test designed for animators.

Four health committees and two health sub-committees (because two zones have large areas) have been established and are functioning in all four health zones. They all met at least once a month during the past six months. They identified and took action on several

health problems such as providing training for a local plumber to repair pipes for their water supply; establishing pre-and post-natal clinics in all four zones to help reduce maternal and infant morbidity and mortality.

Forty-two health posts have been established and provide bi-monthly vaccinations, oral rehydration therapy (ORT), child growth monitoring and vitamin-A supplements. The posts also provide parent education and/or training in ORT, nutrition, child spacing and immunization needs in all four health zones.

Seventy-five health promoters have been identified and trained to help with the health education and motivation of community members. The promoters continue to receive training in immunization schedules, diarrheal disease control, nutrition (including vitamin-A supplements), and child spacing.

A computerized health management information system (H/MIS) is being developed and computerized printouts have helped health promoters to follow women and children delinquent in health care.

Vaccination Coverage Survey Results, May 1991
Children 0-11 Months of Age (n = 314)

AREAS COMPARED	BCG	DPT/P1	DPT/P-3	Dropout Rate	Measles
CS/MEBSH	60%	50%	17%	(66%)	8%
DIST. CAYES*	46%	NA	38%	NA	26%

Vaccination Coverage of
Women Ages 15-49 Years (from H/MIS)

AREAS COMPARED	TT-1	TT-2	Dropout Rate
CS/MEBSH	38.2%	29.4%	(23%)
DIST. CAYES*	NA	10.3% (w/booster)	NA

*information taken from 1990 District Report

ORT - According to a May 1991, random survey 71% of women heard of ORS packets and 44% knew how to prepare them. The team's household sample of 100 mothers with children under two years of age showed 72% of the mothers said they would continue to give food and liquid to children with diarrhea.

NUTRITION - The team's household sampling showed 79% of one-year-olds were weighed at least 4 or more times. Fifty-seven percent of the 23 health promoters interviewed knew how to interpret the growth chart curve. Nearly all promoters know that important advice for mothers is to give undernourished children beans and rice cooked in additional oil.

CHILD SPACING - Twenty-one of the 75 promoters received training from the module presently being taught (#3) which includes child spacing. Eight of the 21 were interviewed and all of them defined family planning as parents having children when they want to as long as they can take good care of them. Nearly all of the mothers interviewed during the team's sampling knew about child spacing. According to the May 1991 random survey, 11% were using birth spacing techniques. The end-of-project objective is 25%.

LESSONS LEARNED

1. The CS field staff learned late in the project the need for establishing priorities. E.g., collecting baseline data after establishing services distorts and diminishes the value of the data.
2. If all the professional staff had understood and appreciated the merits of the CS project, especially during the planning phases, some tension could have been avoided during the stressful project launching stages; the MEBSH staff would have also felt a closer relationship to the project.
3. Had the complexities of the financial management aspects of the project been better appreciated in the beginning, a qualified bookkeeper would have been engaged earlier on in the project.
4. Even had there not been problems of political instability, three years is not sufficient time to determine project areas, identify/hire and train more than 150 people, establish functioning community health committees, establish and supervise 42 health posts, conduct baseline data surveys, develop a health/management information system, develop an Information-Education-Communication (IEC) system and still have a significant impact on the health status of the target population.
5. Had USAID Mission funding not been made available for the next two years through the non-government organization (NGO) called AOPS (Association for Private Health

Organizations), it would have been extremely difficult for WRC and MEBSH to meet payroll for 5 auxiliary nurses and 4 animators. Other expenditures for training, transportation etc. would also have posed problems.

6. The reporting structures required by AID and set up by WRC could have been used more effectively in the field to enhance the management aspects of CS/MEBSH.

7. Attaining community participation in CS activities to the point where the community feels ownership of the Project is time consuming but critical for sustainability.

CONCLUSIONS

CS/MEBSH has achieved or surpassed most of the objectives set forth in the Cooperative Agreement, DIP and MTE. In doing so, the Project has assisted communities to build an excellent health infrastructure -- a major factor towards sustaining CS Project activities. With continued financial assistance, CS/MEBSH will be able to assist more communities to develop health infrastructures and to help them begin generating their own funds -- the other major factor for sustainability.

It should be noted that vaccination coverage is low, and understandably so, because most of the health posts became operational toward the end of the Project. Vaccination sessions are held bi-monthly and not enough time has passed to permit the majority of the children to receive the third dose of DTP/polio. Health post accessibility, though, is good because over 70% of children-under-one received their first dose of DTP/polio.

RECOMMENDATIONS

1. The MEBSH CS project should begin preparing for the time when outside financial assistance either diminishes or ceases completely. Some options for consideration to help with sustainability of services are: focusing more on income generating projects; encouraging community responsibility for providing more health service personnel; initiating cost recovery through fees for service; obtaining more MOH assignee(s); or any combination of these options.

2. Country nationals should assume leadership roles in the CS project as soon as qualified persons can be identified and trained (training funded by the CS Project). This does not exclude expatriates from assisting nationals in leadership positions. However, health projects should not be dependent indefinitely on expatriate direction and assistance. Dependence upon volunteer expatriate leadership raises again the question of sustainability.

3. Continue expanding the number of health zones and developing health infrastructures at the community level much the same way as was done during the first three years of CS/MEBSH -- taking advantage of the lessons learned.
4. Develop a simple, uniform, management/report form to be used at the health post, community (health committee), and central (CS/MEBSH) levels. (See Appendix U for an example.)
5. Engage a micro-enterprise specialist as a short-term consultant to meet with the health committees and help them determine the feasibility of their income generating projects and women's poverty lending projects.

B. EXECUTIVE SUMMARY, WRC CHILD SURVIVAL PROJECT - 24 JULY 1991

A final evaluation of the AID funded CS Project undertaken by WRC in collaboration with MEBSH was conducted at Headquarters in Wheaton, Illinois, and in the field at Bonne Fin, Haiti.

Both agencies being new to CS Project Grant operations and to each other got off to a slow and difficult start. Political instability in Haiti, delays in funding and general misunderstandings also contributed to a stressful beginning. However, working together and learning as they went, they became a good team and accomplished or surpassed most of the objectives that were set forth in the Cooperative Agreement, DIP, and MTE.

Although communications are difficult between WRC and MEBSH, requests from the field were responded to in a timely fashion--less than one week. WRC's CS Director and Administrative Coordinator provided technical and administrative assistance to the Project during their nine visits to the field. Visits were usually initiated by headquarters. Policy was largely set by MEBSH, the CS Project implementor, with guidance from headquarters, the Project facilitator. Headquarters provided a training consultant to the Project during the critical start-up phase with a follow-up visit the following year.

WRC now has two full-time public health specialists and a part-time public health consultant at headquarters. WRC also has expertise in accounting, financial management and micro-enterprise development. The combination of supplementing its own expertise with outside consultants proved to be effective in the CS Project in Haiti and apparently in two other countries as well. CS/MEBSH expressed a desire to continue working with WRC.

WRC always had sufficient cash on hand to meet funding requests from the field. The maximum time required to send money to the field was one week. However, disbursement of money was contingent on WRC receiving the necessary financial and progress reports from the field beforehand. WRC provided \$2,600 more than its agreed

upon share of \$83,500 in the cost sharing budget. AID's share was \$249,000. As agreed upon with AID, WRC's share of the budget was spent on a pro rata basis. The Project overspent about \$11,000 in the procurement category of AID's budget, but approximately \$30,000 remains of AID's total budget to last until the end of Project, September 30, 1991.

WRC's partnership with an indigenous organization which was established and providing health care services avoided a lot of start-up costs. Change in health behavior and development of local health infrastructure as realized by the CS Project in Bonne Fin helps ensure the sustainability factor. These achievements, making the best of a difficult beginning, and the vast experience gained by WRC and MEBSH make them excellent candidates for additional CS grants.

II. ACKNOWLEDGEMENTS

The consultant, on the team's behalf, would like to thank the forty persons listed in this document with whom the team worked. He is especially grateful to Drs. Muriel Elmer and Hubert Morquette for their "above and beyond" participation. And thanks to the people who make it all worth while -- the community.

III. ABBREVIATIONS

AID	Agency for International Development
AOPS*	Association of Private Health Organizations
ARI	Acute Respiratory Infections
BCG	Bacillus Calmette Guerin
CAT	Anti-Tuberculosis Agency
CHP	Community Health Program
CPPN*	Pre and Post Natal Clinics
CS	Child Survival
CSS	Christian Service Society in Bangladesh
DIP	Detailed Implementation Plan
DPT	Diphtheria-Pertussis-Tetanus
EPI	Expanded Program of Immunization
EPS	End of Project Survey
FES	Final Evaluation Survey
H/MIS	Health/Management Information System
ICC	International Child Care
IEC	Information, Education and Communication
IHE*	Haitian Institute for Children
INSA	International Service for Health Associations
IRD	Integrated Rural Development

KAP	Knowledge, Attitude and Practices
MOH	Ministry of Health
MSPP*	Ministry of Public Health and Population
MTE	Mid-term Evaluation
MEBSH	Mission Evangelique Baptiste Sud d'Haiti or Southern Haiti Baptist Evangelical Mission
NA	Not Available
NAE	National Association of Evangelicals
NGO	Non-governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
REACH	Resources for Child Health
PVO	Private Voluntary Organization
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
VACS	Voluntary Agencies for Child Survival (VACS)
WRC	World Relief Corporation (CS HQ, PVO in U.S.)

* French acronyms were given English translations

IV. PURPOSE OF EVALUATION

The purpose of the final evaluation is to assess the accomplishments and impact of World Relief Corporations's Child Survival Project in Haiti; and to evaluate WRC's headquarters performance in providing oversight and support to field activities. Project performance and effectiveness is measured against the goals and objectives established in cooperative agreement OTR-0536-A-00-7224-00 from June 1987 through September 1991. (See Appendices B and C for detailed scopes of work.)

V. METHODOLOGY

In accordance with USAID guidelines for end-of-project evaluations, an independent public health consultant, Harry Godfrey, assisted by staff of WRC, primarily Dr. Muriel Elmer and Ms. Mary Connor, assessed WRC's CS Project at headquarters in Wheaton, Illinois by reviewing CS Project related documents and interviewing appropriate WRC staff members.

After spending three (July 1-3) days assessing WRC headquarters' performance in providing technical and financial oversight and support to their field counterpart, MEBSH, Dr. Elmer and Godfrey went to visit MEBSH in Haiti on July 4. They were

joined there by Dr. Hubert Morquette who assisted with the evaluation of the effectiveness/impact of MEB SH's CS services in the field.

Dr. Phillipe Hirsch, who was to be the second external evaluator, was unable to be with the team. However, Dr. Pierre Joseph, MOH epidemiologist for the Southern Region of Haiti, provided much appreciated assistance to the team.

The team discussed the CS Project with staff from USAID/Haiti, Ministry of Health, MEB SH and other NGOs involved in CS activities. Field records and documents were reviewed; field volunteers, community members and officials were interviewed; questionnaires on mostly technical aspects of CS were prepared by the team and answered by field staff, volunteers, and health committee members. A survey instrument was also prepared and used for mothers (100) with children under two years of age.

Four days were spent in the field (July 9-12) observing vaccination and vaccine conservation procedures, ORT activities, vitamin-A distribution, weighing of babies, nutrition counseling, birth-spacing counseling, record keeping and data collection. Mothers were interviewed to determine vaccination status, knowledge of ORT, birth spacing, etc.

A summary of the results of the evaluation was drafted and debriefings were held with MEB SH, USAID, MOH and AOPS.

VI. MEB SH BACKGROUND (INDIGENOUS PVO IN THE FIELD)

MEB SH is an indigenous PVO that administers Hospital Lumiere, several clinics, a radio station, a rural development program and the Child Survival Project. The Office for the Southern Region of the Ministry of Public Health (MSPP) authorized MEB SH (Authorization # 316 dated February 17, 1984) to conduct community health activities within a 16 km radius of Hospital Lumiere in the community of Bonne Fin located in the District of Les Cayes. The areas listed in the authorization are in the central portion of Haiti's Southern Region. The areas are called Vallee de Plaisance, Marc, Labiche, Gros Marin, Nan Dezi, Piron and Sudre. Vallee de Plaisance was the only area where any significant CS activities were carried out by MEB SH prior to the AID assisted CS Project.

The CS Project is in a rugged mountainous area traversed from north to south by one all-weather road. Other roads in the area are few and in poor condition. Transportation is by private four-wheel drive vehicles, motorcycles, donkeys, walking and/or public buses along the main road. Travel times within the region can be quite time consuming, particularly during the rainy seasons.

The project area is divided into seven natural zones. CS activities are on-going in four of them. Residents live in small settlements that are widely dispersed and earn their living primarily by subsistence farming. The climate is temperate and the soil fertile and well-watered despite the serious effects of deforestation. Primary crops include coffee, corn, beans, millet and tuberous starches.

CS project staff consists of a manager, administrator, two nurse trainers/supervisors, five auxiliary nurse trainers/supervisors, a health educator/trainer, four animators, a bookkeeper and a statistician. The four animators, each living in their respective zones, are responsible for raising awareness of community health issues and encouraging the formation of a community health committee for each zone. These community health committees in turn nominate and elect health promoters for the various sectors within the zones. The health promoters are then trained by project staff to function in their communities. The five auxiliary nurses oversee the various rally posts (health posts) established in each zone. Two government vaccinators and one TB agent from the tuberculosis center have been employed part-time this year to assist in delivering EPI services at these health posts since the workload has increased dramatically. The auxiliary nurses also oversee the CPPN clinics held monthly in each zone to provide mothers and newborns with pre- and post-natal care, tetanus toxoid, vitamin-A and BCG.

VII. FIELD RESULTS

A. Primary Focus and Use of Funding

MEBSH's Community Health Program, assisted by WRC/USAID's cost sharing CS Project, was able to expand its CS services not only in number of interventions but geographically as well. Prior to initiating the CS Project, MEBSH was providing limited vaccination and nutrition surveillance services in eight health posts.

CS/MEBSH is now providing vaccination, ORT, growth monitoring, nutrition counseling, vitamin-A distribution, health education and child-spacing counseling services in 42 health posts bi-monthly with plans for continued expansion to other geographic areas.

CS/MEBSH is also providing monthly pre- and post-natal services in each of the four zones including vitamin-A capsules for women post-partum less < 1 month and BCG for newborns.

B. PVO Organizational Development

After an arduous three years of CS Project development, an impressive, grass roots level health infrastructure was put into place. MEBSH's Community Health Program staff learned to improve work plans and schedules, establish objectives, determine priorities,

improve records systems and reporting procedures, develop IEC materials, establish an H/MIS, collect baseline data, conduct surveys, recruit and/or train numerous staff members and volunteers.

1. Personnel and Volunteers

The following personnel and volunteers were identified, recruited, trained, and are engaged in CS Project activities:

- five auxiliary nurses
- one health educator/trainer
- four community animators
- seventy-five health promoters
- thirty-two traditional birth attendants + 16 prior to CS
- eighty-three community health committee members

The five auxiliary nurses, in response to a 15 question test on technical aspects of vaccinations, vaccine conservation, diarrhea, dehydration, vitamin-A supplements, nutrition, and child-spacing, answered correctly, on average, 96% of the questions. The nurses also knew that 20 minutes of steaming or boiling time is necessary for sterilization of equipment even though all vaccination needles and syringes used in the CS Project are disposable. (See Appendix H for example of questionnaire.)

The four community animators, trained to help communities to organize and to help motivate community health committees and community members, took a test similar to that of the nurses (but designed for animators) answered correctly, on average, 75% of the questions. (See Appendix I for animators' questionnaire.)

The 75 volunteer health promoters (all literate), selected by the community health committees to help with the health education and motivation of the community, continue to receive training in immunization schedules, diarrheal disease control, nutrition, vitamin-A schedules and child spacing. Twenty-one of the promoters were tested on what they need to know to do their jobs (growth monitoring, nutrition counseling, child-spacing counseling, vaccination schedules, etc.). They answered correctly, on average, 84% of the 23 questions. (See Appendix J for health promoters' questionnaire)

Four Community Health Committees were established and are functioning in each of the four zones. They all met at least once a month during the past six months. The committees identified health promoters for their zones to be trained by CS Project staff. They helped establish a total of 42 functioning health posts (bi-monthly) and four pre- and post-natal clinics (monthly). They identified and took action on several health problems such as providing plumbing training for a villager to repair pipes for their water supply; establishing pre- and post- natal clinics in all four zones to help reduce maternal and infant morbidity and mortality. (See Appendix K for committee questionnaire)

2. Health/Management Information System (H/MIS)

In the process of developing a health/management information system, CS/MEBSH completed a census in all the areas of operation. Information from the census has been entered into the CS Project's computerized system. Those persons in the census targeted for vaccinations are maintained in the system by name, area, age, date of vaccination, antigen and series. This is ideal and would permit complete surveillance of subjects delinquent in vaccinations -- if it were feasible. Perhaps it could be feasible (not practical), provided that the census is complete and up-to-date; all vaccinations are recorded, reported and entered; all newborns are reported and entered; all females reaching child-bearing-age are identified and entered into the system; and all women and children becoming too old for vaccinations are programmed out of the system. Although time limitations did not permit an in-depth review of the H/MIS, it appeared that the developing system is too ambitious and too complex and has yet to deal with major needs. E.g., how many vaccinee receive services from other zones or health jurisdictions (they are not being recorded), how many children are seen with diarrhea and the disposition of those cases, how many children are losing or not gaining weight, how many under-weight children are rehabilitated, etc.

It is necessary to maintain an effective records system at all levels of service. It is not necessary though, nor is it feasible, for a central records system in Bonne Fin to keep detailed and up-to-date information on the health status of each targeted individual in its area. Emphasis should be placed first on providing services to the people and less on a records system. If the emphases are wrongly placed the system needs to be revised to accommodate services and not vice versa. E.g., if maintaining a log book at a vaccination clinic takes so much time that some children may not receive their vaccinations, either because the mothers couldn't wait, or time ran out, or mothers refused to return because it takes so much time, then a simple check mark to note what antigen and series was given to which age group is all that is required for record purposes. The personal vaccination card serves as the record by name.

Health post reporting should be on a simple, uniform, preferably one-page form with a copy maintained at the health post or by the local person responsible for the post. This would permit operation of the post independent of a central records system. A compilation of all the health post reports should be compiled on an identical form by a member (or designee) of the health committee of the zone and a copy forwarded to CS/MEBSH in Bonne Fin. It is far more important that the local area people know and keep track of who is delinquent in vaccinations or who needs help to improve the health status of their families than it is to receive information from another source that may or may not be accurate, comprehensive or timely.

What is necessary for a central records system is to know how many people are in its area, how many of those people need services and how many of those people are getting services. It is not necessary to know the names of those people, but only to know why or

why not they are getting the best possible service. On the other hand, the authorities at the community level may need to know who their residents are by name; and the information that exists at CS/MEBSH should be made available to those authorities for them to keep the information up to date.

With some updating/revisions of reporting forms and adjustments in programming, the system would know how many children are seen with nutritional deficiencies and are getting help; how many children are visiting the posts because of diarrhea and what is being done about it; how many women (and what %) are coming to pre- and post-natal clinics; what services are women receiving; if there are sufficient vaccination cards, vaccines, needles and syringes and other supplies available at the health posts; etc. All this H/MIS information is possible to obtain and maintain without further over-burdening a system that, if not checked, will become more unwieldy.

It is important that the H/MIS not only be able to manage effectively the zones currently in operation but to manage additional zones as well. Well designed, simple report forms (bi-monthly or quarterly) should reveal not only if a health post is functioning, but what services are being provided to how many people, and how well. Those posts reflecting poor performance on their reports would be targeted for increased supervision. (See Appendix U for sample of reporting form)

3. Information, Education and Communication (IEC)

Positive results from written tests given auxiliary nurses, animators, health promoters and community health committee members as well as interviews with mothers, attest to effective IEC activities. Among the impressive tools used for IEC are the health songs. See Appendices M through T for informative songs on vaccinations, tetanus, TB, AIDS, oral rehydration, hygiene, breast feeding and family planning.

C. Improvement in CS Design and Implementation

During the mid-term evaluation some objectives were changed and many (66) recommendations were made to improve project design and implementation. The project responded to the recommendations of the MTE and are described in detail in Appendix D.

The grass-roots health infrastructure that was built by MEBSH/CS is evidence that community behavior regarding health has improved dramatically:

community health committees were established and are functioning in each of the four zones;

forty-two health posts (34 under the CS Project) were established and are functioning bi-monthly in all zones;

pre- and post-natal clinics were established and are functioning monthly in each of the four zones;

seventy-five community health promoters were identified, and trained and are functioning in the four zones;

thirty-two traditional birth attendants were identified and trained, joining the sixteen previously trained birth attendants - all forty-eight are currently functioning in the four zones.

MEBSH/CS interventions address the major causes of infant and child mortality in the four zones:

vaccinations are provided bimonthly in 42 health posts in the four zones against measles, polio, tetanus, pertussis, diphtheria, and tuberculosis;

ORT is provided and taught at all 42 health posts to treat children with diarrhea;

babies are weighed routinely, results recorded on growth charts and mothers counseled on the results at all the health posts;

mothers are counseled on the advantages of child spacing;

children with acute respiratory infections (ARI) were not intended to be included in the child survival plans; however, the CS Project area is fortunate to have an excellent mission hospital where ARI cases can be referred.

D. Effectiveness, Impact of Services

Results of the MEBSH/CS initiative during the past three years are charted below. Source of data is from Health/Management Information System (H/MIS), End of Project Survey (EPS), or Final Evaluation Survey (FES). Date of source of data is included. Any revisions of objectives recommended by the mid-term evaluators are shown in the last column. For details of data, see Appendix E.

DESCRIPTION	ORIGINAL OBJECTIVE	RESULT	SOURCE OF DATA	REVISED BY MTE
1. Women 15-49 yrs to get TT-2	25%	28%	H/MIS 7/91	60%
2. Pregnant women to to get TT-2	60%	80%	FES 7/91	Eliminated
3. Mothers continue food, liquid for children w/ diarrhea	50%	45%	EPS 5/91	40%
4. Mothers know how and use ORS for children w/ diarrhea	50%	43%	EPS 5/91	40%
5. Children 0-59 mos. weighed 4 times yearly	50%	NA	(see Appendix E)	
6. Children losing wt. to be weighed bi-monthly	50%	NA	(see Appendix E)	70%
7. Children must show weight gain	50%	NA		Eliminated
8. Children to receive vitamin-A	50%	NA	(see Appendix E)	
9. Mothers receive vit-A 1st mo. post partum	10%	25%	FES 7/91	30%
10. Couples using birth spacing methods	10%	11%	EPS 5/91	25%
11. H. committees funct.	4	4	Observed	
12. H. posts functioning	40/50	42	Observed	
13. H. promoters trained and functioning	70/80	75	Observed	
14. Community animators trained & functioning	3	4	Observed	

DESCRIPTION	ORIGINAL OBJECTIVE	RESULT	SOURCE OF DATA	REVISED BY MTE
15. Auxiliary nurses trained & functioning	4	5	Observed	
16. Haitian as Director, Community H. Services	1	1	(See appendix E)	
17. Haitian h. educator/ trainer trained	1	1	Observed	
18. Traditional birth attendants trained	20/30	40	Observed	
19. Health training curricula revised		Completed in 1990		
20. Baseline data survey		Completed Dec. 1989		
21. Purchase computer & other equipment		Completed 1989		
22. Develop H/MIS		Functioning in 1989		

D.1 Vaccination Coverage

Vaccination coverage is not good because most of the health posts were operational less than six months at the time of the evaluation. Reliability of the information is questionable. E.g., the number of children under one year of age should be closer to 1,000 rather than 370 as reflected in the following tables. The totals of the FOUR ZONES do not correspond with the combined totals of the individual zones (H/MIS printout).

VACCINATION STATUS OF CHILDREN, 0 - 59 MONTHS
(SOURCE: H/MIS 7/91)

ZONE ONE - PLAISANCE

AGE/ MOS.	NO.OF CHILD.	DTP/P-1	DTP/P-3	DROPOUTS	MEASLES	BCG
0-11	86	76(88%)	29(34%)	47(62%)	7 (8%)	84(98%)
12-35	427	325(76%)	236(55%)	89(27%)	243(57%)	312(73%)
36-59	495	355(72%)	296(60%)	59(17%)	320(65%)	317(64%)
0-59	1008	756(75%)	561(56%)	195(26%)	570(57%)	713(71%)

ZONE TWO - LABICHE

AGE/ MOS.	NO.OF CHILD.	DTP/P-1	DTP/P-3	DROPOUT	MEASLES	BCG
0-11	115	94(82%)	28(24%)	66(70%)	9 (8%)	110(96%)
12-35	476	286(60%)	143(30%)	143(50%)	227(48%)	297(62%)
36-59	645	317(49%)	196(30%)	121(38%)	251(39%)	241(37%)
0-59	1236	697(56%)	367(30%)	330(47%)	487(39%)	648(52%)

ZONE THREE - CHANGIEUX

AGE/ MOS.	NO.OF CHILD.	DTP/P-1	DTP/P-3	DROPOUTS	MEASLES	BCG
0-11	109	81(74%)	29(27%)	52(64%)	9 (8%)	99(91%)
12-35	321	262(82%)	192(60%)	70(27%)	228(71%)	278(87%)
36-59	411	308(75%)	229(56%)	79(26%)	268(65%)	284(69%)
0-59	841	651(77%)	450(54%)	201(31%)	505(60%)	661(79%)

ZONE FOUR - TROIS MANGOTS

AGE/ MOS.	NO.OF CHILD.	DTP/P-1	DTP/P-3	DROPOUTS	MEASLES	BCG
0-11	75	35(47%)	5(7%)	30(86%)	1(1%)	53(71%)
12-35	394	203(52%)	88(22%)	115(57%)	138(35%)	204(52%)
36-59	371	168(45%)	97(26%)	71(42%)	141(38%)	136(37%)
0-59	840	406(48%)	190(23%)	216(53%)	280(33%)	393(47%)

ALL FOUR ZONES

AGE/ MOS.	NO.OF CHILD.	DTP/P-1	DTP/P-3	DROPOUTS	MEASLES	BCG
0-11	370	274(74%)	84(23%)	190(69%)	24(7%)	334(90%) *
12-23	701	515(74%)	319(46%)	196(38%)	392(56%)	557(80%) *
24-59	2828	1705(60%)	1154(41%)	551(32%)	1411(50%)	1510(53%)
0-59	3899	2496(64%)	1556(40%)	940(38%)	1825(47%)	2402(62%)

* age breakdowns different than those from individual zones

VACCINATION STATUS OF WOMEN, AGES 15 - 49 YEARS

TETANUS TOXOID - 2ND DOSE - BY ZONE

(SOURCE: H/MIS 7/91)

ZONE	NO.OF WOMEN	NUMBER VACCINATED	PERCENT VACCINATED
1 - Plaisance	1235	426	34.5
2 - LaBiche	1770	395	22.3
3 - Changieux	0883	422	47.8
4 - Trois Mangots	<u>1033</u>	<u>173</u>	<u>16.7</u>
TOTAL	4821	1416	29.4

D.2 Disease Surveillance

Dr. Morquette reviewed hundreds of Lumiere Hospital records to establish the number of hospitalized cases and deaths due to tetanus, neonatal tetanus and diarrhea/dehydration during the past ten years. This should be helpful to measure the impact of CS Project interventions in the future. Cases and deaths due to measles and pertussis should be reviewed as well. When date of birth, date of onset of disease, and date(s) of vaccination is recorded in the records an analysis of disease transmission is possible.

The records review showed that six cases of neonatal tetanus were admitted to the hospital from 1981 through 1990. Half of them died. During the same time period, 60 cases of other tetanus were hospitalized and nearly 1/3 (18) of them died.

Twenty-two children under five years of age from the Bonne Fin area were admitted to the hospital in the last ten years for diarrhea and dehydration. Fifteen of the cases were severe of which two died. Both were treated with ORS and I.V. solutions. The other 20 cases were treated with ORS only -- four of them had nasal gastric tubes. The 22 children spent an average of 16 days each in the hospital.

Ninety-two children under five came from areas outside Bonne Fin and were hospitalized for the same pathology (dehydration-diarrhea) of which 15 (16%) died.

E. PVO, Host Government Cooperation

CS/MEBSH has a good working relationship with the Ministry of Health (MOH) at the central, regional and district levels. In 1984 the MOH formally authorized MEBSH to provide health services in the Bonne Fin area in the District of Cayes. The MOH supplies MEBSH with vaccines, needles and syringes, vitamin-A capsules and various health cards and report forms. The Ministry provides the CS project with technical guidance and technical assistance (vaccinators). Dr. Joseph, the Ministry's epidemiologist for the Southern Region, assisted with the final evaluation of CS/MEBSH. MEBSH provides monthly activity reports to the Ministry.

The Haitian Child Institute provided technical assistance to CS/MEBSH to collect baseline data and conduct KAP surveys. Other agencies involved in CS such as International Child Care (ICC) and World Concern provided information on training strategies and resources for training materials. A short-term training consultant from International Services for Health Associations (INSA) assisted the Project for two/three weeks in 1988 and 1989. AOPS (Association for Private Health Organizations) has provided the CS project with some funding for a feasibility study in the past and will fund the continuation of the project for the next two years.

F. Sustainability

In order to enhance the sustainability of a CS Project, WRC chose as a partner a local, viable PVO in Haiti that was already involved in community health activities. MEBSH has demonstrated its capability to develop and maintain its own health structure. It has been involved in community health with emphasis on maternal and child health since 1984 -- four years before receiving AID funding for CS through WRC.

MEBSH'S intentions are to continue CS activities with or without specific CS Project assistance. WRC's intention is to continue to assist CS/MEBSH in the future when it can; but it won't be able to do so to the extent it did under the AID/WRC CS Agreement. WRC is presently considering covering the training costs for the next phase of the Project which are not covered under the grant obtained from AOPS. (CS/MEBSH just received a two-year, \$100,000 grant through AOPS, an AID funded organization.) CS/MEBSH, benefitting from lessons learned in long-term planning, is considering a proposal with WRC for a second centrally-funded CS grant as a follow-on to the AOPS grant.

Health services provided by PVOs have been going on for so long and so extensively in Haiti that they could be regarded as part of the public health infrastructure. Cooperation and collaboration between the MOH and the PVOs have a long history in Haiti and probably will continue for a long time to come.

The government provides PVOs with some commodities, technical assistance, health policies and guidance while some PVOs provide staffed medical facilities and, even more important from a primary-health-care point of view, assistance to communities to help them develop their own health service capacity. CS/MEBSH has provided such assistance.

Community action to help establish health services is the most important part of the sustainability equation. Although funding would appear to be equally important, some communities, with sufficient assistance to help them organize and fund sound income generating projects, could become less and less dependent on outside funding for health services.

The development of the community health infrastructure from elections of health committee members to the training of TBAs and health promoters are the most critical indicators used to track Project sustainability. Using these indicators, the number of community health committees and sub-committees established and functioning (6), the number of health promoters elected, trained and working (75), the number of TBA's identified and trained (40), and the number of health posts established, functioning and reporting routinely (42) are evidence of the change that has occurred in CS Project sustainability.

Concerning the financial part of the sustainability question, cost recovery (fees for services) has not yet been attempted. Income generating projects, though, have been initiated in each of the four zones.

Zone 1, Plaisance, started a cattle raising project in September 1990. A disagreement between contracting parties interrupted the project and the \$1,500 loan was returned. A fish pond project is under consideration.

Zone 2, Labiche, finished a water project and is planning a community store project.

Zone 3, Changieux, borrowed \$500 to butcher a cow weekly to combat malnutrition in the community and it's working well. The health committee requested and received authorization from the MOH to assume responsibility for the day-to-day administration and supervision of the Changieux health clinic. The committee subsequently arranged for medical supervision of the clinic to be provided by the Lumiere Hospital.

Zone 4, Trois Mangots, just borrowed \$1,000 in May 1991 to start a food storage project. The sub-committee in Vassal also recently borrowed \$500 to start a pig raising project.

No Project costs have been covered as yet by income from the above activities and it is premature to judge what impact the activities will have on financial sustainability of the CS Project. It would seem prudent, though, to provide some expert assistance to the communities to help insure the success of income generating projects.

G. Project Finances

CS/MEBSH's projected AID/WRC three-year funding was \$285,000 of which \$258,400 were actually spent as of May 30, 1991. The balance of \$26,600 is obligated through the end-of-project, September 1, 1991. This amounts to between \$3 and \$4 per year per person for approximately 26,000 people in the CS Project area.

The Project exceeded the budgeted amount on the line item for "procurement" by 30%. Nearly \$60,000 was projected and \$85,400 was spent. Salaries are included in this line item.

The major portion of the recurrent budget is for personnel which is reasonable because of extensive training, teaching, educating, motivating and organizing that is essential for developing health infrastructures at the community level. This is a difficult and time consuming task which is perhaps best done by PVOs. And in order to make the task cost effective it is essential that the CS Project expand the development of health infrastructure to more communities and ensure that the communities themselves assume responsibility for maintaining/sustaining health services.

VIII. LESSONS LEARNED FROM THE FIELD

1. The CS field staff learned late in the project the need for establishing priorities. E.g., collecting baseline data after establishing services distorts and diminishes the value of the data.
2. If all the professional staff had understood and appreciated the merits of the CS project, especially during the planning phases, some tension could have been avoided during the stressful project launching stages; the MEBSH staff would have also felt a closer relationship to the project.
3. Had the complexities of the financial management aspects of the project been better appreciated in the beginning, a qualified bookkeeper would have been engaged earlier on in the project.
4. Even had there not been problems of political instability, three years is not sufficient time to determine project areas, identify/hire and train more than 150 people, establish functioning community health committees, establish and supervise 42 health posts, conduct baseline data surveys, develop a health/management information system, develop an Information-Education-Communication (IEC) system, change behavioral patterns in the community and still have a significant impact on the health status of the target population.
5. Had USAID Mission funding not been made available for the next two years through the non-government organization (NGO) called AOPS (Association for Private Health Organizations), it would have been extremely difficult for WRC and MEBSH to meet payroll for 5 auxiliary nurses and 4 animators. Other expenditures for training, transportation etc. would also have posed problems. A basic tenet for undertaking projects that provide preventive and curative health services is the necessity to be able to sustain those services.
6. If Haitian leadership with appropriate credentials had been pursued more rigorously by MEBSH one year ago when Dr. Morquette announced his departure, a Haitian may now have been available to be the Director.
7. Had adequate financial and programmatic reporting systems been put in place at the beginning of the project, several difficulties could have been averted. Finances could have been managed more effectively, overspending in the procurement category could have received prior approval and project activities might have moved along at a better pace.
8. If clear objectives and precise indicators had been identified at the onset of the project and been built into a manual H/MIS, many subsequent problems could have been averted. Progress could have been measured continuously and appropriate management

decisions made throughout the time of the grant. A manual H/MIS could have provided an adequate backup when the project was plagued with computer difficulties.

9. The provision of vitamin-A capsules is, at best, a questionable solution to a questionable problem in the Bonne Fin area where vitamin-A-rich produce grow in abundance. Strong emphasis should be placed on teaching/communicating the benefits of using natural sources of vitamin-A in the diet. Focusing on this type of health behavior helps contribute to the sustainability of the Project's efforts. (If government policy is to give vitamin-A to women and/or children in all areas of the country, then that policy must be respected until the question is raised with the MOH and the policy subsequently changed.)

10. The poverty in the CS area points to a need for some sort of income generating scheme for mothers that would help them raise their standard of living and hopefully help them to provide better health among their children.

11. The reporting structures set up by WRC and required by USAID were not used well as learning/assessment tools which could have enhanced management decisions in the field. This problem should be studied more carefully so that reporting becomes part of the management process at the community level as well as the MEBSH level and on up through the MOH levels.

12. It takes time to get community participation in a CS project. Initial goals should be modest in order to allow time to get the community on board to the point where community leaders feel ownership of the project. This is a critical building block in any structure to be sustained.

13. Health volunteers are essential, especially at the community level. Those who are not dedicated soon leave. Those who are dedicated should not be overwhelmed with work. Free medical care and per diem for training sessions provide incentives for volunteers but should not be interpreted as salaries. Otherwise, sustainability becomes a problem.

IX. RECOMMENDATIONS FOR THE FIELD () = person responsible & time

1. The MEBSH CS project should begin preparing for the time when outside financial assistance either diminishes or ceases completely. Some options for consideration to help with sustainability of services are: focusing more on income generating projects; encouraging community responsibility for providing more health service personnel; initiating cost recovery through fees for service; obtaining more MOH assignee(s); or any combination of these options. (Steven Nelson - measurable progress by the end of 1992)

2. Country nationals should assume leadership roles in the CS project as soon as qualified persons can be identified and trained. This does not exclude expatriates from assisting nationals in leadership positions. However, health projects should not be dependent indefinitely on expatriate direction and assistance. Dependence upon volunteer expatriate leadership raises again the question of sustainability. (Chavanne Jeune - measurable progress by the end of 1992)

3. Continue expanding the number of health zones and developing health infrastructure at the community level much the same way as was done during the first three years of CS/MEBSH -- taking advantage of lessons learned. (Steven Nelson - measurable progress by the end of 1992 and again in 1993)

4. Develop a simple, uniform management/report form to be used at the health post level and two copies forwarded to the community health committee of the zone for compilation on an identical form. The health committee should send a copy of the compilation and a copy of each health post report to CS/MEBSH in Bonne Fin. The reporting schedule will be determined by the frequency of the health post sessions (bi-monthly for the moment). (Wilson Macenot - before April, 1992)

5. Review the MOH's policy of oral rehydration therapy and if the policy, in the absence of ORS packets, is to promote increasing intake of fluids and not sugar/salt solutions, the policy must be respected. ORS packets should be made available at least at all health posts and preferably should be available in all households. The packets could be sold so that they can be restocked as needed. (Steven Nelson - before March 1992)

6. Review the MOH's policy of supplementing vitamin-A in children under-five and if policy does not require it, determine whether it is necessary in the Bonne Fin area; and if the time, effort and expense of vitamin-A distribution could be better spent on more crucial health care needs. Vitamin-A requirements in the Bonne Fin area may be best dealt with through nutritional education. (Great for sustainability too). (CS/MEBSH Consultant, Dr. Hubert Morquette - before March, 1992)

7. Engage a micro-enterprise specialist as a short term consultant to meet with the health committees and help them determine the feasibility of their income generation projects and a women's poverty lending project. Make more money available to these committees along with more stringent criteria for use of the money to help ensure that these projects are a success. (Chavanne Jeune - Before March, 1992)

8. Hospital Lumiere records should reflect, when possible, vaccination status on all cases of immunizable diseases, dates of vaccinations and date of onset of disease. (Hospital Medical Director - before July 1992)

9. Hospital Lumiere should notify the CHP office immediately of any measles cases so that CHP can prevent a potential epidemic in their project area by providing vaccinations

to susceptibles or requesting MOH/Cayes to do so. (Hospital Medical Director - immediately)

10. Hospital Lumiere should provide immunizations at least twice weekly. (Hospital Medical Director - before January, 1992)

11. All known cases of neonatal tetanus should be investigated by CS/MEBSH to prevent future cases from similar causes. (Steven Nelson or his designee - immediately)

12. The CS/MEBSH fax machine should be installed in the Integrated Rural Development Program Office in Les Cayes to better facilitate communications to and from the CS/MEBSH Project in Bonne Fin (Bonne Fin is not on the Haiti telephone network). (Chavanne Jeune - before January, 1992)

X. WRC CS HEADQUARTERS BACKGROUND

World Relief Corporation (WRC) is the international relief, development and refugee service arm of the National Association of Evangelicals (NAE), a membership organization consisting of 42,000 evangelical Christian churches in the United States representing 48 denominations and 4.6 million church members. WRC is also associated with the Evangelical Foreign Missions Association with 101 member missions supporting over 14,000 missionaries.

As a wholly-owned subsidiary of the NAE, WRC is related to the World Evangelical Fellowship, which represents national associations of evangelicals in 57 countries. Relationships with these national associations enable WRC to reach out to local communities in virtually every country around the world without the need to establish or maintain a separate infrastructure. WRC supports a variety of programs in 29 countries, assisting approximately 1.5 billion people.

WRC's purpose is to enable the church to meet the needs of the poor and suffering throughout the world. To fulfill this purpose, WRC supports disaster relief, long-term development and refugee assistance projects overseas and in the U.S. WRC's operational strategy is to support indigenous national and local counterparts which work with local church groups to carry out relief and development activities in their own communities.

Development strategies of the early 1980s were based on the Declaration of Alma Alta in 1978 highlighting the importance of primary health care. WRC determined that primary health care, including child survival approaches, could contribute to indigenous organizations grassroots community development efforts. As a result, WRC began to integrate these approaches into its other development programs.

In 1987 WRC received funding from USAID for Child Survival projects in Haiti (implemented by the indigenous counterpart, MEBSH) and Bangladesh (implemented by the indigenous counterpart, CSS), and in 1989 USAID approved a WRC proposal to carry out a Child Survival project in Honduras.

This year the inclusion of the following statement into WRC's revised mission statement signified yet another step taken by WRC towards a formal commitment to the health sector:

... WRC aims to work primarily through the local church by assisting it with economic development and health improvement ...

XI. FINDINGS AT HQ (WRC)

A. Relationships Between Field and Headquarters

WRC, working as a facilitator in a partnership with MEBSH who implemented the CS Project, left decision making largely in the hands of MEBSH. WRC provided support in advising and guiding Project staff and monitored progress towards achievement of the objectives.

Because some of MEBSH's Community Health Program field staff were not convinced of the merits of a child survival grant and did not have much choice in doing the project, acceptance of headquarter's supporting role by some field staff was not enthusiastic at times--especially when headquarters insisted on receiving activity and financial reports, progress on objectives, etc. This awkward atmosphere persisted, although less and less as time went by, until the final evaluation -- and perhaps still does. However, once the majority of the field staff learned the importance of advance planning, establishing priorities and objectives, tracking and evaluating activities and preparing and analyzing reports, they also came to appreciate the results of their efforts -- improving and expanding health services. Attitudes then became more positive, skills increased and achievements helped boost morale.

Communications between headquarters and field are difficult because there are no telephone or cable facilities in Bonne Fin. Radio contact is possible, though, between Haiti's capital city, Port au Prince (P au P), and Bonne Fin. A message by phone from headquarters to P au P and relayed by radio to Bonne Fin (and vice versa) is not the ideal way to communicate, but response time to field requests for support from headquarters has been acceptable -- varying from one to five days.

WRC's CS Director and Administrative Coordinator made nine visits to MEBSH's CS project after the project got underway in June 1988. Six of the visits were for technical and administrative reviews and assistance, and three of the visits were to assist with the mid-term and final evaluations. WRC's CS Director has attended seven CS related workshops, conferences and/or seminars; the CS Administrative Coordinator attended five.

WRC arranged for a well experienced training consultant to assist CS/MEBSH for nearly three weeks during their critical start-up phase for training, supervision and strategy planning in June 1988. A two-week follow-up visit was provided by the same consultant the following year. The positive value of these short-term consultant visits was evident during the final field evaluation when staff, volunteers and community members were observed and/or interviewed. (See summary of field evaluation)

WRC recently employed a new Administrative Coordinator with an MPH who will provide technical and administrative assistance to the Director for Child Survival Projects. WRC's strategy of supplementing its own public health expertise with other public health consultants' expertise, when appropriate, to assist field staff has met with approval from the field.

B. Financial Management and Tracking

WRC has always had sufficient cash on hand to meet funding requests from the field. Their funding mechanism is uncomplicated making field disbursements easy and fast. The maximum time required to send money to the field is one week after receiving the request. Note, however, that before the field appreciated the need to provide timely financial and activity reports, funding from headquarters was contingent on receiving those reports.

Approximately \$218,000 of USAID's projected \$249,400 has been spent as of April 30, 1991, leaving about \$30,000 for the remaining five months of the project. The project overspent about \$11,000 of the budgeted \$30,600 in the procurement category.

WRC exceeded its share of its \$83,500 cost sharing budget by about \$3,500. The project overspent almost \$16,000 in the procurement category which was budgeted for \$28,300. As agreed upon in the CS cooperative agreement between USAID and WRC, WRC's share of the budget was spent on a pro rata basis.

PROJECTED AND ACTUAL EXPENDITURES
USAID/WRC/MEBSH CHILD SURVIVAL PROJECT IN HAITI
June 1, 1987 - May 30, 1991
(Budget figures in 000's and are approximate)

	Year-1		Year-2		Year-3		Year-4		Total	
USAID	Proj/	Act*	Proj/	Act*	Proj/	Act*	Proj/	Act*	Proj/	Act*
Functn	62.7/00.0		53.9/18.4		55.7/48.5		00.0/53.7		172.3/131	
Procur	22.6/00.0		3.0/ 3.6		5.0/00.0		00.0/ 8.6		30.6/41.3	
Overhd	19.5/00.0		13.1/10.5		13.9/22.3		00.0/12.9		46.5/45.7	
							Total		249.4/218	

WRC

Functn	00.0/00.0	27.8/10.5	5.3/15.9	22.1/14.0	55.2/42.0
Procur	00.0/00.0	00.0/17.3	26.1/18.4	2.2/ 8.5	28.3/44.1
				Total	83.5/86.1

* Projected/Actual

C. Institutional Development of MEBSH

WRC has a list of over 20 persons involved in CS related activities with whom they have consulted and exchanged ideas in the past year. WRC was fortunate in locating an excellent training consultant who spent nearly three weeks with MEBSH staff when they were launching their CS initiative in June of 1988. She visited MEBSH again the following year for two weeks. The field staff appreciated her visits; and the knowledge, attitudes and practices of the nurses, auxiliaries, animators, health promoters, community health committee members and villagers observed during the final evaluation confirmed their appreciation.

D. Project Monitoring and Evaluation

In the beginning WRC had difficulties monitoring the costs and progress of the Project because, frequently, financial and activity reports were either not submitted or were very late from the field. The Project itself could not monitor costs in the beginning because no viable system was set up and no one with bookkeeping skills was assigned to the task. After several visits, frequent communications, and making allocation of funds contingent on receiving reports, the problem was rectified.

Development of the community health infrastructure was initially the major criterion used to measure progress. Indicators to measure this progress are the number of community health committees and sub-committees established and functioning, the number of health

promoters elected, trained and working, the number of TBA's identified and trained, and the number of health posts established, functioning and reporting routinely.

Indicators to measure performance of the Project are vaccination coverage for women and children, treatment of diarrhea cases in children, controlling weight loss in children, couples' knowledge and use of birth spacing methods, and vitamin-A distribution for children and post-partum mothers.

Indicators to measure impact of the Project will be reduction of morbidity and/or mortality caused by immunizable diseases, diarrhea and malnutrition.

Data collection and analysis was another one of the difficulties experienced during the initial stages of the Project. Collection of baseline data was not done at the beginning of the Project. Data collection is now included in job descriptions of field staff. A statistician has been employed and is receiving on-the-job training, a part-time data entry person has been engaged and the administrator of the Project, who has made considerable progress in learning data collection and analysis, is responsible for continuing the development of H/MIS.

WRC worked with CS/MEBSH staff in the preparation of annual reports and Project evaluations. The mid-term evaluation was translated into French for the benefit of the local staff, making it possible for the staff to share with the Project beneficiaries. Communications (feedback) as evidenced by headquarters logs and records was frequent between WRC and CS/MEBSH.

E. Relationships with Host Government, Community and Other Organizations

Communications between the MOH and WRC/MEBSH are frequent and the MOH seems to appreciate the CS Project's efforts in the Bonne Fin area. As mentioned before, the MOH provides technical assistance and commodities to the Project and the Project reports routinely to the MOH on its progress. The evaluation team appreciated very much the participation of Dr. Pierre Joseph, the MOH's epidemiologist for the Southern Region.

Good collaboration exists with other organizations. World Concern in Port au Prince helped facilitate communications (FAX service) between WRC Headquarters in Illinois and CS/MEBSH in Haiti. The Haitian Child Institute provided technical assistance to help CS/MEBSH collect baseline data and conduct surveys. AOPS provided funding for a feasibility study. Several other agencies involved in CS activities such as INSA and ICC provided information on training strategies and resources for training materials.

What started out as a trying relationship between some members of the MEBSH team and WRC (see section IX A) later developed, after several visits and many communications, into an effective working relationship. There is now a desire on the part of both organizations to continue working together. Although there apparently will not be an immediate follow-on, centrally-funded, AID cooperative agreement for the two

organizations, it appears that WRC will continue to assist CS/MEBSH to complement the health policies and programs of both the Government of Haiti and USAID.

F. Sustainability

The strategy for ensuring sustainability in CS Projects as viewed and written by WRC is to create permanent change in Health behaviors while ensuring that a structure has been put in place to support those behaviors. The structure utilizes community health workers and community health committees working in cooperation with the MOH. Establishment of such a structure is facilitated by an indigenous PVO in partnership with WRC.

The community is encouraged to take charge of the process of change. The community is responsible for, aware and proud of, the impact of the Project on its people. Activities that promote better child health are to be managed by the community to avoid creating dependency on non-permanent external assistance.

Income generating projects have been implemented in the CS Project but have not had sufficient time to prove their worth as sources of revenue. Revenues from these and other projects could perhaps help support health service costs; but short-term assistance from a micro-enterprise specialist would be better able to make this determination and at the same time, with appropriate counseling, enhance possibilities for success.

As mentioned before, PVOs could be considered part of Haiti's health infrastructure and will probably continue as such into the foreseeable future. Communities prepared to take charge of their health services will require supervision either from the MOH or its PVO designee. Ideally, PVOs would facilitate community independence, expand assistance to other communities and maintain sufficient supervision to assure quality of service and progress.

At this time neither WRC nor MEBSH plan to cease CS project activities. They both plan, however, in their expansion of CS activities to make the benefits of their efforts as sustainable as possible.

XII. LESSONS LEARNED AT HQ (WRC)

Many of the lessons learned in the field could be applied to WRC Headquarters as well. Both WRC and MEBSH, being new to the CS Project Grant workings, felt they learned and benefitted greatly from the experience; but more importantly they felt they helped provide services to the public that, without the AID agreement, would not have been possible.

In addition to lessons learned listed in Section VI, WRC cited the following:

1. A delicate balance must be realized between respecting a partner's autonomy yet achieving adherence to requirements of the Grant;

2. Communications between the two parties must be frequent, open and honest.
3. Short-term funding with long-term objectives often creates at headquarters as well as in the field a "do for" rather than a "do with" work mentality.

XIII. CONCLUSIONS

The WRC/MEBSH partnership accomplished most of the objectives set forth in the Cooperative Agreement, DIP and mid-term evaluation.

This partnership approach provides impetus for local initiative and minimizes external initiatives which are difficult to sustain.

Working with an indigenous organization which is already established and providing health care services eliminates a lot of CS project start-up costs.

Sustainability of CS activities is far more likely to occur with indigenous organizations who will remain in place.

Institutional development of the indigenous PVO and competently trained local residents enhance sustainability under the partnership approach.

These achievements and the experience that WRC and MEBSH gained from the CS Project make them both excellent candidates for additional AID/CS grants.

XIV. RECOMMENDATIONS FOR WRC () = person responsible & time period

1. WRC should continue its involvement in CS Activities working with indigenous partners experienced in health delivery services and established in developing countries. (Bastian Vanderzalm - at each opportunity but not to exceed WRC management capacity)
2. Short-term consultants with expertise in a particular field (epidemiology, management, H/MIS, etc.), preferably host country nationals, should be used to supplement WRC's public health expertise when indicated. (Muriel Elmer - as needed)

APPENDIX A -- PLACES VISITED AND PERSONS CONTACTED

WORLD RELIEF CORPORATION HEADQUARTERS - WHEATON, ILLINOIS

Mary Conner, Administrative Coordinator, CS Program

Muriel Elmer, MSN, Ph.D., Director, CS Program

Kenneth Graber, Micro Enterprise Development Coordinator

Robert Landrebe, Acting Executive Director

Kevin McKemey, Latin America/Caribbean Regional Director

Robert Mullins, Staff Accountant

Howard Searle, M.D., MPH, WRC Consultant (Former Act.Dir., WRC/CS)

Bastian Vanderzalm, Associate Exec. Dir., International Programs

USAID/HAITI - PORT AU PRINCE

*

John R. Burdick, Dptmt Chief, Health/Population/Nutrition Office

Frantz M. Louis, Proj. Coord., Voluntary Agencies for CS (VACS)

* Representing David Eckerson who was on travel status

MINISTRY OF HEALTH/HAITI

Dr. Jean Andre, Director, EPI/CDD, Port au Prince

Dr. Robert J. Jeune, Acting Director, Southern Region, Les Cayes

Dr. Pierre A. Joseph, Epidemiologist, Southern Region, Les Cayes

Dr. Gerald Lerebours, Director General, Port au Prince

MEBSH - BONNE FIN, HAITI

Arnold Alcima, Animator, Trois Mangots

Marie Rosaire Charles, Auxiliary Nurse

Nancy Doney, Secretarial Assistance

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Rose Laure Francois, Auxiliary Nurse

Marie Lucie Idoxie, Auxiliary Nurse

Andre Forges, Statistician

Aroll Marcelus, Animator, LaBiche

Dr. Francesca Hyacinthe, Director of Medical Program

Chavannes Jeune, Administrative Counsel, MEBSH

Wilson Maceno, Administrator, CS/MEBSH

Evelt Mentor, Animator, Plaisance

Marie Marthe Merisier, Health Educator/Trainer

Dr. Hubert Morquette, CS Consultant, (former CS/MEBSH Manager)

Stephen Nelson, Director, Community Health Program, CS Manager

Elisabeth Newton, R. N., FNP, Coordinator of Clinical Activities

Rose Marie Poline, Auxiliary Nurse

Jennifer Paultre, Bookkeeper/Secretary

Charles Pearce, Administrator, Lumiere Hospital

Joy Powell, R. N., Supervisor

Paulin St. Hilaire, Animator, Changieux and Bonne Fin

Irmane Thelusma, Auxiliary Nurse

Katy Wolf, MD, Medical Director, Lumiere Hospital

OTHER NGOs IN HAITI - PORT AU PRINCE

Dr. Phillipe Hirsch, Consultant, IHE

Dr. Frantz Simeon, Director General, AOPS

Luca Spinelli, Resident Coordinator, REACH/HAITI

Bill Tarter, Director for Latin America, World Concern

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WRC Child Survival Project/Haiti
Final Evaluation
SCOPE OF WORK

Purpose:

To assess the accomplishments and impact of World Relief Corporation's Child Survival project in Haiti; and to evaluate WRC's headquarters performance in providing oversight and support to field activities. Project performance and effectiveness will be measured against the goals and objectives established in cooperative agreement OTR-0536-A-00-7224-00 (from 6/87 to 9/91), and subsequently in the project's Detailed Implementation Plan (DIP) and mid-term evaluation.

Objectives:

1. To assess WRC's progress towards and effectiveness in carrying out the child survival service delivery and training activities specified in the grant and subsequent documents, which are aimed at improving the health status of women of child bearing age and children under one.
2. To analyze and evaluate the effectiveness of WRC's headquarters in providing technical, financial, policy and programmatic oversight and support to field activities in Haiti. Particular attention should be focused on the programmatic implications of WRC not directly implementing the program, but rather providing funds to Mission Evangelique Baptiste Sud D'Haiti to carry out grant activities.
3. To assess WRC's capacity for carrying out child survival projects, as well as to determine what, if any, problems and constraints are preventing them from reaching the goals and objectives outlined in the cooperative agreement with FVA/PVC.
4. To develop specific recommendations for WRC regarding technical modifications to field implementation and headquartered-centered responsibilities, including: training design, field backstopping, monitoring and

- Is data from the Health Information System (or other Management tracking systems) being used to refine project, or to redirect resources or staff time?
- How is feedback of data provided to project staff, counterpart organizations, and project beneficiaries?

Relationship with Host Government, Community and other organizations in country

- What has been the involvement of the MOH, universities, local institutions, or other NGOs in terms of project design, financial support or project implementation?
- How successful is WRC's partnership with the Mission Evangelique Baptiste Sud D'Haiti? Is counterpart assuming ownership of the project?
- Does project complement policies and programs of host government and A.I.D.?

Sustainability

- What financial and organizational strategies have been implemented to promote project's sustainability?
- Has WRC established revolving funds or other cost-recovery mechanisms? If so, how successful have they been? Is it likely that revenues could eventually cover the cost of services?
- What efforts are being made to phase out of certain activities/areas, and to turn responsibility over to the community/host government?
- Does the Mission Evangelique Baptiste Sud D'Haiti plan to cease Child Survival project activities at any specified point? If so, do host government or other institutions demonstrate commitment/ability to sustain project benefits once NGO's support ceases?

evaluation, administrative procedures, and staff development.

6. To examine what steps are being taken to institutionalize project in order to assure the sustainability of benefits.

Evaluation Outputs:

The evaluation team leader will be responsible for preparing and delivering one unbound copy of the final evaluation report to A.I.D. by September 1, 1991. Prior to this, the team leader will provide by July 26, 1991 a copy of the draft report concurrently to WRC and A.I.D. for their review and comments.

The report should provide the following:

1. An assessment of WRC's/Mission Evangelique Baptiste Sud D'Haiti's progress towards the goals of the Grant Agreement.
2. An evaluation of WRC's/Mission Evangelique Baptiste Sud D'Haiti's performance and effectiveness in Haiti, as well as the problems and constraints that are influencing progress towards the established goals.
3. Recommendations to WRC's/Mission Evangelique Baptiste Sud D'Haiti's for actions to support their future progress.

The body of the report should also contain the following:

- Table of Contents
- Executive Summary
- Key Findings and Recommendations
- Purpose of evaluation
- Team composition and study methodology
- Annexes
- Scope of Work (SOW)
- List of documents consulted
- List of individuals/organizations consulted

Methodology:

The evaluators will conduct their assessment using the following:

1. WRC Cooperative Agreement
2. WRC/Haiti Detailed Implementation Plan
3. Prior internal and external evaluations of field operations and headquarters (as available)
4. Annual Reports of Project

5. Other documents considered relevant
6. Interviews with WRC staff, host country counterparts, Ministry of Health (MOH), USAID/Haiti, and other individuals considered relevant
7. Interviews with and/or surveys of project beneficiaries

Schedule:

July 1 to 3	Headquarters evaluation/briefing in Wheaton, IL.
July 4 to July 16	Field evaluations in Haiti
July 17	Debriefing at USAID/Haiti
July 18	Depart Haiti
July 26	Debriefing at WRC/Wheaton

Evaluation Questions and Issues: The FVA/PVC/CSH PVO Child Survival Final evaluation guidelines (copy attached) should serve as the primary reference for questions to be addressed in this evaluation. Described below are additional questions and issues that FVA/PVC/CSH has developed to direct the evaluators during the course of the evaluation. Some questions are more relevant for the field than headquarters, and vice versa. The evaluation team should use these questions as a guide; it is not expected that each will be separately addressed in the final report.

Relationship between field and headquarters

- How does headquarters (HQ) support field efforts? What role does the Wheaton, IL. office play in project management and monitoring?
- What is the turn-around time between field requests for information, technical assistance, etc. and responses from headquarters?
- Do headquarter's funding mechanisms promote smooth project implementation?
- How many trips have headquarter's staff made to field sites? What has been the nature of the visits (i.e.- to provide technical assistance, monitor status of project, etc.)?
- Is technical assistance from headquarters to field typically initiated by HQ, field, or either?

July 5, 1990

Dear Colleague,

Taking into consideration the recommendations of the PVO Task Force on Child Survival Final Evaluation, this office has developed the following guidelines for end-of-project evaluations that should be followed by CSIII projects and by those CSII projects that received no-cost extensions: ~~etc.~~

1. All PVO Child Survival II³ and III⁵ projects are required to carry out a final evaluation before the official end-of-project date. This evaluation is the responsibility of the PVO country project.
2. All PVO CSII and III projects are required to submit only one final project report. Your final project report is the report of your final evaluation and should include an end-of-project financial accounting.
3. Core questions and issues to be addressed by all evaluation teams are described in Attachment 1. Attachment 2 is provided to help with the calculations of the immunization activity indicators. Submission of Tier 2 survey data is also acceptable. In all cases the evaluation team should cite the source and year of data presented in the final report, and make some estimate of the data's validity and reliability.
4. The final evaluation report should include a comparison of project objectives with documented achievements and cite the source of data presented in the report with some estimate of reliability and validity. The evaluation team should use the Detailed Implementation Plan (DIP) as their basic project design document and source of project objectives, target population, etc. unless those objectives and targets were revised in the Annual Report or mid-term evaluation submitted to A.I.D. The evaluation team should have copies of the A.I.D. grant response letter and the technical recommendations for strengthening the DIP. The team should use both A.I.D. and PVO monitoring and reporting data as well as additional information from field observations, focus groups, small studies, etc.
5. The final evaluation team should carefully assess which strategies worked and which did not, and comment on why certain things happened or did not happen. The information provided by the team on "lessons learned" will be used to guide the development and implementation of ongoing and future A.I.D. funded Child Survival projects.

6. At least one external evaluator familiar with child survival interventions must be on the final evaluation team. An external evaluator is someone not associated with the organization to be evaluated. This person can be a host country national (e.g., a Ministry of Health official), a member of an international donor organization or university, an independent consultant, etc. We encourage that at least one member of the project field staff and one headquarters representative be included on the final evaluation team.
7. In a limited number of cases, A.I.D. will send a consultant to join the final evaluation team. The selection of which projects will have an A.I.D. sponsored evaluator will be a joint decision of the PVO and FVA/PVC. PVOs who have requested an A.I.D. sponsored evaluator for the final evaluation should follow up with a regular technical assistance request form and draft a scope of work to discuss with A.I.D.
8. All Child Survival II and III end-of-project evaluation reports should be submitted to FVA/PVC within 90 days following official end-of-project date. September 30, 1990 is the common end-of-project date for most CSIII projects unless extensions have been formally approved by FVA/PVC. All evaluation expenses must be incurred before the end-of-project.

Please contact your project officer should you have questions or require clarification of these guidelines.

Sincerely,

John McEnaney
 John McEnaney
 Chief, Child Survival and Health
 Bureau of Food for Peace
 and Voluntary Assistance

Encl: 2

- what interventions by project
 determine, w/ W.R. tasks of other
 team members.

- Chrono file -

- Telebs

- FAPS

- Monthly Reports.

~~DTP~~

- Annual Reports

- ~~Mid Term Eval~~ APPD. C page 2

- Add grant reports letter

CORE QUESTIONS AND ISSUES TO BE ADDRESSED BY THE
PVO CHILD SURVIVAL III PROJECT FINAL EVALUATION TEAM

I. Evaluation Goals

To Estimate the Overall Accomplishments of Child Survival Grant
Funding in Terms of:

- A) Primary Focus and Use of Funding i.e., extent to which PVO took advantage of the opportunity to focus and refine health activities, and expand to new communities.
- B) PVO Organizational Development i.e., improved technical capacity of the field staff, increased technical capacity at headquarters, new HQ backstopping strategies developed, improved health information systems, etc.
- C) Improvement in Project Design and Implementation Plans i.e., more realistic setting of objectives and phasing strategies, state-of-the-art intervention protocols, appropriateness of specialized targeting strategies for various at-risk groups, etc.
- D) Effectiveness/Impact of Services i.e., changes which have occurred in reaching target communities and populations; effective coverage of at-risk groups; success of community mobilization schemes (reflected by immunization drop-out rates); change in mothers' use of ORT in target area; comparison of project objectives with documented achievements. Please cite sources of data.
- E) PVO/Host Government Cooperation i.e., changes which have occurred in the PVO's relationships with MOH/EPI, MOH/CDD, PHC unit or other relevant government agencies; evidence that the CSIII project has contributed to or otherwise strengthened government activities in the health and child survival sector.
- F) Sustainability Strategies i.e., extent of community's belief that project meets its needs; level of community and government commitment to the project as demonstrated by the amount of resources (human, financial and material) contributed; government health authorities' perceptions of project effectiveness; success of cost recovery/income generation schemes;

- phase over of project leadership to country nationals.
- G) Project Finances i.e., planned versus actual expenditures; recurrent costs.
- H) Lessons Learned by the CSIII Country Project.

II. Specific Questions to be Addressed:

A. Project Focus & Use of Funding

What has been the major focus of CS project funding: (a) to support and deliver health outreach services from established sites or (b) to support and improve MOH local service delivery through training, monitoring, and supervision or (c) to increase community awareness of health needs and demand for health services or (d) to change health behaviors or (e) some other focus?

Has CS funding primarily been used to: (a) develop entirely new activities or (b) refine or improve existing ones?

Has CS funding primarily helped the PVO to: (a) expand to new geographic areas and new communities or (b) continue ongoing activities in a specific area?

B. Organizational Development

B1. Human Resources

At each level, does the field staff have the training and skills necessary to perform the tasks required? Are expatriates or host country nationals performing significant administrative, training, evaluation or health service activities?

What management and technical training has been carried out to support staff development? Was the training appropriate and effective?

* Have the staffing patterns and skills at PVO headquarters been adequate to provide necessary specialized management and technical support to CS project?

B2. Use of Technical Resources

* Were comments and recommendations from the original A.I.D. grant approval letter and technical review of the Detailed Implementation Plan (DIP) addressed?

Was the technical backstopping available from PVO HQ staff utilized appropriately and in a timely manner by the project being evaluated?

* Was A.I.D.-funded technical assistance used by the project? Was other TA utilized to support the project, i.e., MOH, National University, etc.? Was the TA considered appropriate and useful?

* Did any project staff participate in A.I.D. supported Child Survival workshops or conferences? Was it a useful experience?

B3. Health Information Systems

* Was a baseline study carried out to select and refine target groups and priority problems? What were the lessons learned from the survey experience?

Has the project developed an information system that routinely provides adequate and timely data for monitoring the costs, progress and effectiveness of the activities? Do the persons responsible for data collection and analysis have the training and skills necessary to do the job?

Has the information been used by field level administrators and managers to redirect resources, staff time, etc.? Has the information been used to provide feedback to project staff and community?

C. Project Design and Implementation

C1. What actions has the project taken at the community and household level to improve health behavior?

C2. Appropriateness and Targeting of Activities

Do the CS interventions provided by the project address the major causes of infant and child mortality in the area?

Did the project focus its activities on proper target groups i.e., infants 0-11 months, children whose growth is faltering, pregnant women?

What strategies have been used to target services to specific at-risk groups?

Did project immunization activities appropriately

concentrate on coverage of infants 0-11 months rather than older children? (Calculate the % of infants 0-11 months who received DPT1 immunizations in the past year compared to the % of children 0-59 months who received DPT1 in the past 12 months)

Did project ORT activities target children 0-36 months? (Calculate, for example, % of cases of diarrhea in the last two weeks for children 0-36 months treated with ORS and/or a recommended home fluid.)

Did project nutrition activities target children 0-24 months? (Calculate, for example, % of children 0-24 months who participated at least three times in growth monitoring activities in the past 12 months)

C3. Specific Interventions

For each child survival intervention which the PVO country project specified on its 1989 A.I.D. Child Survival and Health Reporting Schedule, the evaluation team should assess:

a) Objectives and Phasing of Country Project

Were the objectives of this intervention specific, measurable, given a time frame, realistic and feasible for this PVO?

b) Technical Adequacy of Intervention Design and Implementation Strategy

Do project field training materials, supervision and health communication reflect state-of-the-art knowledge and address field constraints?

c) Quality of Field Activities

Did the health workers have adequate, timely supervision? Were there provisions for in-service refresher training? Has the PVO addressed the issue of the cold chain functioning? How are immunization drop outs followed? Is there follow up to growth monitoring activities when growth faltering occurs? What techniques are used to judge competence of health workers in ORT?

D. Effectiveness/Impact of Services i.e., changes in coverage, health behaviors or health/nutrition status of the target population (use available data and field

visit observations, etc.)

D1. Documented Achievement of Objectives

Please attach a chart which lists each project objective, and the final measurement of achievement of the objective. State sources of data.

D2. Effectiveness in Targeting Services

What evidence is there that the targeting strategies have been effective in the specified at-risk groups? - Specifically, the evaluation team is requested to answer the questions below, using Attachment 2 to aid in calculating rate data.

✓ What is the antigen-specific immunization coverage of infants in the service area? (calculate the % of infants 0-11 months who received BCG, DPT3, Polio3 and measles immunization in the past 12 months)

What is the tetanus coverage of childbearing age women in the service area? (calculate % women 15-49 who received TT2 immunization in the past year)

Do mothers of children 0-59 months know how to correctly mix and administer ORS?

How effective have project activities been in terms of community motivation? What is the percentage drop of infant immunization coverage from DPT1 to DPT3 this past year? What is the percentage drop from TT1 to TT2 coverage in the past 12 months?

E. PVO/Host Government Cooperation

What has been the involvement of the MOH, local institutions, and other PVOs in the project in terms of project design, financial contributions and staff involvement?

Have any changes occurred in PVO-MOH collaboration at local, district or national levels?

What evidence is there that the CSIII project has contributed to or otherwise effected government activities in the health sector?

F. Sustainability

F1. Community Motivation and Participation

How have communities participated in the design and implementation of health services? What are the # of functioning health committees, and how often have they met in the past 12 months?

Do the community leaders feel that the project activities meet current health needs?

What resources has the community contributed that will help ensure that project activities will continue after donor funding ends?

F2. Commitment of the MOH

Do MOH personnel perceive CS activities as being effective?

What is the commitment (in financial, human and material resources) of the MOH to project activities once CS funding ends?

F3. Administrative Efforts to Cut Costs and Increase Efficiency

What strategies - both financial and organizational - have been implemented to promote the sustainability of the project?

What indicators are used to track sustainability? Is there documented change in sustainability by use of these indicators?

F4. Cost Recovery/Income Generation

What cost-recovery mechanisms have been implemented? Have any income generating activities contributed to meeting the cost of health activities?

G. Project Finances

Assess planned expenditures compared to actual expenditures.

How does project calculate recurrent costs? Are these costs reasonable given the environment in which the project operates?

H. Lessons Learned and Recommendations

H1. What are major lessons learned from the past three years of CS project implementation?

H2. Recommendations

How can the field project improve its effectiveness in reaching CS objectives?

How can the PVO headquarters improve managerial and technical backstopping of CS field activities?

How should A.I.D. continue or improve its support to PVO country projects working in Child Survival?

Attachment 2

GUIDE TO CALCULATIONS FOR RATE DATA
FOR PVO CSIII FINAL PROJECT EVALUATION

This sheet is provided to clarify the calculations requested in the final evaluation guidelines. It is designed to be used with the latest A.I.D. Child Survival and Health Reporting Schedule which the country project submitted to AID/Washington. The number in the parentheses refers to the schedule # and question # where the value may be found in the 1989 Child Survival and Health Reporting Schedule. If the project has recent survey data, this information may be used. Also, please cite sources of data for the evaluation team calculations. The most recent information is preferable in every case.

1) % SERIES COMPLETION BY ANTIGEN FOR INFANTS DURING THE PAST
12 MONTHS

% BCG Coverage of Infants

$$\frac{\text{\# of infants 0-11 months immunized for BCG (3-3)}}{\text{\# of live births (1-5.j)}} \times 100$$

% DPT3 Coverage of Infants

$$\frac{\text{\# of infants 0-11 months immunized for DPT3 (3-3)}}{\text{\# of live births (1-5.j)}} \times 100$$

% Polio3 Coverage of Infants

$$\frac{\text{\# of infants 0-11 months immunized for Polio3 (3-3)}}{\text{\# of live births (1-5.j)}} \times 100$$

% Measles Coverage of Infants

$$\frac{\text{\# of infants 0-11 months immunized for Measles (3-3)}}{\text{\# of live births (1-5.j)}} \times 100$$

2) % SERIES COMPLETION TETANUS TOXOID FOR PREGNANT WOMEN

% TT2 Coverage of women who have delivered
in the last 12 months (3-10a)

If data has been collected for women of reproductive age, rather than for pregnant women, this data should be included in the report.

3) PROJECT'S ABILITY TO TARGET/FOCUS ON INFANTS UNDER ONE YEAR OF AGE, DURING THE PAST 12 MONTHS

$$\frac{\# \text{ of infants 0-11 months who received DPT1 (3-3)}}{\# \text{ of live births (1-5j)}} \times 100$$

compared to

$$\frac{\# \text{ of children 0-59 months who received DPT1 (3-3)}}{\# \text{ of children 0-59 months (1-5b + 1-5c + 1-5d)}} \times 100$$

4) DROP OUT BETWEEN INITIAL AND FINAL IMMUNIZATION FOR SELECTED ANTIGENS IN THE PAST 12 MONTHS

DPT Drop Out Rate
(for immunizations given to infants 0-11 months)

$$\frac{\text{DPT1 (3-3)} - \text{DPT3 (3-3)}}{\text{DPT1 (3-3)}} \times 100$$

Polio Drop Out Rate
(for immunizations given to infants 0-11 months)

$$\frac{\text{Polio1 (3-3)} - \text{Polio3 (3-3)}}{\text{Polio1 (3-3)}} \times 100$$

APPENDIX D -- RESPONSE TO MTE RECOMMENDATIONS

1. Clarify and revise project objectives for CS interventions.

RESPONSE - Project objectives were revised and/or clarified when deemed appropriate by CS Project staff.

- 1.1. Mobilize to complete remaining two baseline surveys and analyze data within 60 - 90 days.

RESPONSE - The last baseline was done in November '89 which included a new area called Vassal to increase the population to 26,000 people.

- 1.2. Revise targeted percentages and upgrade activities for EPI.

RESPONSE - Target percentages were revised and immunization activities started as scheduled in the following zones:

Zone	Scheduled	Started
Changieux	May '90	May '90
Labiche	July '90	May '90
Trois Mangots	November '90	October '90

- 1.2.2. Upgrade cold-chain process.

RESPONSE - A refrigerator was purchased. An Electrolux was not available so a General Electric was chosen instead.

A current record of vaccine stock and expiration dates are kept by the refrigerator.

Vaccines which have been removed from the refrigerator for vaccinations sessions and returned when not used are being marked for use before other vaccines.

Vaccines are being rotated so that the oldest are used first.

Vaccines are well arranged to allow air to circulate around them.

Vaccines are no longer stored in plastic bags in the refrigerators.

DTP and TT are no longer kept on the top shelf of the refrigerator and are checked routinely to make sure they have not been frozen.

The cold-chain is being respected when the vaccines are taken from the refrigerator to the vaccinations sites and back.

All vaccine vials opened during a vaccination session are destroyed after the session.

A French translation of cold-chain technical material was obtained, read by the staff, and presented to them in a seminar.

The CS/MEBSH cold-chain policy was developed based on these technical materials and the EPI ESSENTIALS by REACH.

1.2.3. Vaccinate all newborns at Hospital Lumiere with BCG.

RESPONSE - Hospital Lumiere does not fall within the seven zones where CS/MEBSH is working or plans to work; however, CS staff continue to give vaccinations at the hospital once a month after returning from a health post. Hospital staff are being encouraged to provide the service themselves.

1.2.4. Schedule vaccination sessions according to formula.

RESPONSE - Vaccination sessions are scheduled bi-monthly for each health post and if number of vaccinee in area are insufficient to warrant a session, the post will be eliminated and vaccinee referred to the next closest post - if vaccinee are too numerous, staff will be increased, sessions will be of longer duration and/or number of posts will be increased.

1.2.5. Vaccinate all children who attend vaccination sessions.

RESPONSE - No target children are refused vaccinations.

1.2.6. Vaccinate all children who attend vaccination sessions without their vaccination card.

RESPONSE - All target children are vaccinated whether they have a vaccination card or not.

1.2.7. Track non-attenders following DPT/P-1.

RESPONSE - Community health promoters track women and children delinquent in health services.

1.3. Decrease targeted percentages for those understanding and using ORT and finalize appropriate formula.

RESPONSE - Although MTE recommended percentages of mothers knowing how to mix and administer ORT at end of project be reduced from 50% to 40%, the May 1991 random survey showed that over 70% of mothers knew how to mix and administer ORT and they also knew to continue to feed and give fluids to children with diarrhea.

1.4. Revise targeted percentages for growth monitoring and nutrition.

RESPONSE - Objectives for growth monitoring were increased from 50% to 70% of malnourished children to be weighed four times per year. The objective of children expected to gain weight was eliminated.

2.1.1. Obtain outside assistance in compiling and analyzing survey data.

RESPONSE - IHE helped compile and analyze survey data. One technician from Cayes (MSPP) was hired to help enter the data in the computer.

2.1.2. Consider the temporary delay of on-going activities in order to complete baseline survey.

RESPONSE - It was not necessary to delay providing service; baselines were realized.

2.1.3. Consider conducting a 30-cluster survey in the absence of completed analysis of baseline data by December.

RESPONSE - Baseline survey was done.

2.1.4. Consider delegation of responsibility for the survey process as it continues.

RESPONSE - The Project Manager increased the amount of time he devotes to the Project and assumed responsibility for the surveys.

2.1.5. Provide adequate supervision for interviewing teams.

RESPONSE - One supervisor was trained and assigned for every five interviewers.

2.1.6. Consider revision of interviewer training process.

RESPONSE - Responded to in 4.6 below.

2.1.7. Consider option of compensating interviewers.

RESPONSE - Money was given to the Health Committees who assumed responsibility for ensuring adequate incentives provided for the surveyors.

2.2. Plan how Health Information System can be used to benefit Project.

RESPONSE - H/MIS is now seen as a tool for managing Project activities and making informed management decisions.

2.3. Restructure role of statistician and obtain additional assistance in data processing.

RESPONSE - Additional assistance was obtained from a young Canadian short term missionary, Steven Knox.

2.3.1. Give statistician additional responsibility in data analysis.

RESPONSE - This recommendation is still under consideration.

2.3.2. Provide statistician with further training in computer.

RESPONSE - This recommendation is still under consideration.

2.3.3. Obtain assistant data entry/records clerk.

RESPONSE - Mrs. Sandy Agnew helps in data entry as a part time staff member.

2.3.4. Purchase fan for statistician's office.

RESPONSE - A fan is being used in statistician's office.

2.4. Upgrade record keeping system.

RESPONSE - Cases of diarrhea are not yet being recorded. Records have been established for growth monitoring, vaccine and growth card inventory and distribution, iron and vitamin tablet distribution, and pre and post natal visits.

2.5. Structure part-time staff position devoted to monitoring supplies and materials.

RESPONSE - CS Administrator, Wilson Maceno, provisionally assuming responsibility for this position.

2.6. Consider conducting cross-sectional impact survey.

RESPONSE - Cross-sectional survey will be considered after all Project initiatives are satisfactorily underway. Monthly CS/MEBSH report results are being compared with Regional and National results.

3. Develop activities at the community level.

RESPONSE - Activities are underway in communities of all four zones.

3.1. Maintain targeted objectives for number of functioning health committees.

RESPONSE - Elections for committee members were held in the four zones and health committees are functioning in each of them. The committee members of Changieux are still enthusiastic and hold regular meetings as do the health committees in the other

Zones. Changieux, though, has not been successful in achieving the 11 objectives they set forth in 1988. This is due partially to the political turmoil that prevailed in Haiti until just recently.

3.2. Maintain targeted objective for establishment of rally (health) posts.

RESPONSE - Forty-two health posts were established or maintained. Thirty-four were established through the CS Project.

3.3. Maintain targeted objective for training of village health promoters.

RESPONSE - Seventy-five health promoters were trained (attended instructions in two modules -- the minimum requirement for training). Twenty-one of the 75 promoters received instructions on the 3rd module.

3.4. Re-evaluate incentives in health promoter remuneration.

RESPONSE - In addition to health benefits, \$25 was given to promoters for attending instructions in the first module and \$50 for modules 2 and 3 which were taught every three months. After instituting this, a lot of promoters expressed willingness to re-join the program. Promoters with three years experience have not yet been retrained.

3.5. Maintain targeted objective for number of traditional birth attendants (TBAs) to be trained.

RESPONSE - Forty TBA's were trained by MEBSh, eight of which were trained prior to the CS project.

3.6. Maintain targeted objective for training of animators.

RESPONSE - Four animators were trained. After the mid-term evaluation two additional motorcycles were purchased so that all four animators now have transportation.

4. Strengthen staff training components.

RESPONSE - All aspects of point 4 were taken into consideration. Health education and health training materials were revised. Recommendations of Paulette Chaponniere were implemented. Animators were given additional training. The refresher course for animators was not held. After the MTE, a supervisor from IRD in Les Cayes came regularly three times a week to Bonne Fin to supervise the animators. But results of this arrangement were not considered adequate and the practice was discontinued in January, 1991. All Project personnel received refresher training in EPI.

5. Intensify focus on sustainability.

RESPONSE - With additional funding and outside expertise, more income generating projects will be undertaken. The proposed out-patient clinic to be constructed in the

Bonne Fin area did not materialize because of insufficient funds. It was planned to have the clinic charge for services to help finance the CS Project.

6. Streamline Project Management.

RESPONSE - Difficulties among key leaders of the CS Project were resolved. Collaboration between the manager and his assistant improved satisfactorily. The manager worked at the Project office every morning for at least three hours. One day a week he directed a coordinating meeting with the director of technical services, the director of administrative services, the director of education and the coordinator of the auxiliaries. All the job descriptions were revised as mentioned above. Responsibilities were divided among the manager and the two coordinators. The MEBSH Director did not come to Bonne Fin every week but the manager met with him from time to time discuss issues.

Last October the manager transferred to Porte au Prince but continued to visit the project in Bonne Fin 4 - 5 days a month. He continued to do CS Project work in Port au Prince and coordinating CS activities with the Director of Technical Services, his assistant in Bonne Fin.

A Fax machine was purchased and placed in the house of the Director of MEBSH in Les Cayes. In addition to the long delay before installation, the machine never quite served as intended.

Retreats for the staff were organized. Relationships among staff members improved considerably as observed during the final evaluation.

Collaboration improved between the Hospital and the CS Project. Hospital chaplains play health education cassettes for the patients every morning. The Administration agreed to continue giving hospital privileges to health promoters and health committee members. Hospital doctors continue to participate in community based clinics. Hospital records are made available to the Project for studying morbidity and mortality on tetanus, diarrhea and dehydration.

The DIP was translated into French and copies distributed to the staff. The MTE was translated and discussed with the staff. Objectives of the MTE were compiled in one document, distributed to the staff and displayed on the walls.

A short wave radio receiver not purchased.

APPENDIX E -- ACHIEVEMENTS OF DIP OBJECTIVES

Project objectives and outcomes are presented here in the same order as they originally appeared in the DIP. Data is drawn from the Final Evaluation Survey in July, 1991 (FES 7/91), the End of Project Survey in May, 1991 (EPS 5/91) and the Health Information System as of the end of May, 1991 (HIS 5/91).

1. 25% of the 15-49 year old women will receive TT2
(Revised per MTE recommendation to 60%).

OUTCOME: HIS 5/91 indicates 28.8%.

2. 60% of the pregnant women will receive TT2.

OUTCOME: FES 7/91 indicates 80% of women with babies under two years old received TT2. (This objective eliminated per MTE recommendation since all women 15-49 are targeted by the project to receive TT2.)

3. 50% of mothers/grandmothers will continue to give food and fluids to children with diarrhea. (This objective reduced to 40% per MTE recommendation.)

OUTCOME: 72% of mothers say they continue to give food to a child with diarrhea (FES 7/91). According to EPS 5/91, 44.6% of mothers said they continue to give food. 96% of mothers continue to give liquid to children with diarrhea (FES 7/91), and according to EPS 5/91 only 40% of mothers continue to give liquid (EPS 5/91).

The large discrepancies between these data may well be explained by the differences in sampling between the two surveys. The FES 7/91 sample selected only mothers with children under age two, whereas the EPS 5/91 selected mothers of children under five. The mothers of children under two would be more likely to have recently attended a health post to get their children immunized, and since health education is a major component of health post activities, this variable could account for the greater number who knew that they should continue to give food and liquids to a child with diarrhea. Also, more than twice as many health posts were operational for mothers with children under two than for mothers with children two years of age and older (16 of the 42 health posts or 38% were opened after January 1, 1991).

4. 50% of mothers/grandmothers will know how to correctly mix and administer ORS. (Revised per MTE recommendation to: 40% mothers will know how to prepare and use ORS when their children have diarrhea.)

OUTCOME: 83% of mothers know how to prepare ORS, either the home mix or from the packets (FES 7/91). Only 51% knew how to prepare the ORS sachets. 44.3% knew how to prepare sachets on the earlier survey (EPS 5/91) and 42.8% said they would administer ORT after the first or second liquid stool (EPS 5/91).

5. 50% of children 0-59 months who are adequately nourished will attend at least 4 growth monitoring sessions annually.
6. 50% of children with decreasing weights will be weighed bi-monthly. (Revised per MTE recommendation to: 70% of children 0-59 months with decreasing weights will be weighed bi-monthly.)

OUTCOME: The computerized H/MIS was never programmed to track these two objectives. An attempt was made in February 1991 by Dr. Morquette to sift through the printouts and manually extract the data for the first objective (# 5). Since Zone 1 was the only Zone in which growth monitoring had been on-going for more than a year, that zone was selected to assess this objective. 17.6% of the adequately nourished children were weighed 4 or more times during the past year. However, this sample was small and not representative of the project as a whole. The second objective (# 6) was impossible to assess even from the printouts.

On the other hand, the FES 7/91 did survey children 12-23 months for number of times weighed. The results showed that 79% of these sample children had been weighed 4 or more times during the past year. This data gives some indication of the level of growth monitoring activity that is occurring presently in the CS project. Of all the children under-2 surveyed in the same survey, 81% had been weighed at least one time.

7. 50% of children being weighed will be gaining weight.

OUTCOME: Eliminated per MTE recommendation as an unrealistic objective.

8. 50% of children will be given vitamin-A.

OUTCOME: This objective is too vague (age, dosage and schedule not specified). However, since the MSPP policy is to give children from 0-59 months vitamin-A every four months, it has also become the project protocol. Unfortunately, this objective was not programmed into the H/MIS for analysis, although it is recorded every time a child receives a dose of vitamin-A. In February, 1991, a manual assessment of the data in Zone 1 showed that 32.3% of the children in the Zone 1 printouts had received more than 2 doses of vitamin-A. Again, this can provide only a rough estimate for one Zone and cannot be generalized throughout the project.

Consequently, this objective was included in the FES 7/91. The results showed that 55% of children 6-23 months had received more than one dose of vitamin-A.

Please note that there was no apparent evidence of vitamin-A deficiency in the Bonne Fin area and although there is probably no harm in providing vitamin-A supplements, efforts and resources could be better spent in the Bonne Fin area on more important health problems such as diagnosis and treatment of tuberculosis, sexually transmitted diseases, etc.

9. 10% of mothers will receive vitamin-A during first month post-partum. (Revised per MTE to read: 30% of mothers to receive vitamin-A first month post-partum.)

OUTCOME: The FES 7/91 data indicates that only 25% of mothers of children under-2 have received vitamin-A during the first month post-partum. Several constraints have contributed to not meeting this objective. First, Haitian culture dictates that a new mother remain in her house during the first month postpartum in order to avoid having the "cold" enter her body. Consequently, most new mothers do not present themselves to the CPPN clinics until after the first month post-partum. Secondly, most of the TBAs who were originally expected to give the mothers vitamin-A are illiterate and are not able to record this activity. The new strategy is to have the health promotor visit the new mother and give the vitamin-A capsule. This strategy, however, is just now being instituted.

Please note again that in the Bonne Fin area where vitamin-A deficiency does not appear to be a problem, a health promotor could better spend his/her time ensuring that all newborns were registered and presenting for vaccinations, child-bearing-age women were receiving TT vaccinations, pregnant women were attending pre-natal clinics, undernourished children were receiving proper care, etc.

10. Number of couples using temporary or permanent child spacing methods to increase 10% annually. (Revised per MTE to 25%.)

OUTCOME: The EPS 5/91 showed that 11.3% of the couples are using a birth spacing method.

11. Health committees will be functioning in all CS zones.

OUTCOME: All four zones now have a health committee elected and functioning. One zone is so large that it now has one main health committee and a subcommittee to oversee a more distant area of the same zone. During the evaluation several committee members were interviewed and two health committee meetings were attended by the evaluator. There is evidence of strong community participation through the health committees.

12. 40 - 50 bimonthly rally (health) posts will be established and operating.

OUTCOME: As of July, 1991, 42 health posts have been established and provide bi-monthly services throughout the year. Sixteen (38%) of those posts have been established within the last 6 months.

13. 70-80 village health promoters will be chosen by the health committees and trained by the CS staff.

OUTCOME: 75 health promoters have been chosen and trained and are now working in their communities.

14. Three animators will be trained in community health work.

OUTCOME: Four animators have been trained and are working in their communities.

15. Four auxiliary nurses will be trained in community health work.

OUTCOME: Five auxiliary nurses have been trained and are working in the project.

16. Two Haitians will be chosen and trained to take over the positions of director of community health services and health educator.

OUTCOME: Two Haitians were identified for these positions. The health educator was sent to France for training and just returned to the position in July, 1991. A Haitian administrator has been receiving on-the-job training in directing CS for over a year now. He has yet to receive formal training. It was planned for him to go to the U.S. for a short course at Boston University in the spring of 1991, but in light of the tremendous needs in the project and the expense of the educational program at Boston U., it was deemed best for him to remain in the project for the time being.

17. 20-30 TBAs will be trained.

OUTCOME: 40 TBAs were trained.

18. Health training curricula will be revised.

OUTCOME: Curricula was revised and taught to the health promoters and some health committee members who were available to attend.

19. Baseline survey will be conducted.

OUTCOME: The baseline survey was not completed until December, 1989. The baseline analysis was not completed until the last year of the project. This was due to the project computers being plagued with problems. Needless to say, this constraint has made it very difficult to measure any progress until recently.

20. Appropriate equipment and supplies will be purchased to facilitate completion of the project. A computer will be purchased to help compile data.

OUTCOME: Equipment and supplies were eventually purchased. Difficulties were encountered, including malfunctions in the computers. Due to a computer virus and difficulties in programming, three computers were purchased before development of an H/MIS was possible.

21. A health/management information system will be developed.

OUTCOME: The H/MIS is functioning reasonably well at this time. However, programming of some objectives was never adequate to track what progress was being made. Most notably, the growth monitoring objectives. Children were being weighed but only now are attempts being made to identify defaulters at risk.

The DIP's schedule of activities was for three years. However, due to political instability in Haiti the project was postponed for one year. It wasn't until the beginning of the second year, June 1988, that the first allocation of funds were made to the project. Consequently, almost no activities, other than the completion of the DIP in October 1987, occurred during the first year and the project was given an extra year for a no cost extension.

During the second year most of the first year objectives were realized except that no additional health posts were established. Two additional zones, Zone 2 (Labiche) and Zone 3 (Changieux), were targeted and baselines were completed in March and May, 1989, respectively. The first animator had been hired by MEB SH prior to the grant and placed in Zone 2, LaBiche, to initiate the community development process. He was also responsible for Zone 1, Plaisance. A second animator was hired in January, 1989, and placed in Zone 3, Changieux. A computer, office equipment and a vehicle were purchased. Income generating options were discussed with the health committees. They first discussed the possibility of a store selling construction supplies. However, they decided against it due to the insecurity in the country at the time. One committee asked for a small business loan for buying and selling agricultural products at a profit. This loan was granted the following year. Mr. Adrien Cherisson became the part-time coordinator and supervisor for the animators.

During the third year most of the second year objectives were realized. Two more animators were hired, in Zone 2, La Biche, and Zone 4, Trois Mangots. Four nurse auxiliaries were also hired. Fifty-one village health promoters in Zones 1,2 and 3 were identified and started their training. Some drop-outs occurred. Baselines were conducted in Zones 1, Plaisance, and 4, Trois Mangots, in November, 1989, and December, 1989, respectively. Fifteen TBAs were identified in Zones 1, 2 and 3 and started their training. Three motorcycles were purchased. The MTE was conducted in July-August, 1989, and changes in the administration were inaugurated. Mary Mericier was hired as the health educator in December, 1989, and Wilson Macenot was hired as the administrator in January, 1990. Loans for income generation projects were given to the health committee in Plaisance to buy agricultural projects.

During the fourth and final year, all of the third year objectives were met. Thirty-one health posts were established making a total of 42. Twenty TBAs were trained. A KAP survey was completed in December, 1990. A final project survey was completed May, 1991. Mary Merisier went to France in October, 1990, for training in public health and hygiene at Pierre and Marie Curie University and took several courses (modules) on health administration and surveys at Bichat Hospital in Paris. She returned to the CS Project in July, 1991. MEB SH/CS made \$500 for income-generation available to the

health committee of Changieux to initiate a beef butchering business. The business did not fully materialize and the \$500 loan was repaid to MEBSH/CS.

APPENDIX F-ORGANIZATIONAL CHART FOR MEBSH

MEBSH INSTITUTIONAL MINISTRIES

M. Chavannes Jeune, Director

Director, CS Project

MEBSH MEDICAL MINISTRIES

Dr. K. Wolf, Director

CHILD SURVIVAL PROJECT

S. Nelson, Manager

Tech. Services Coordinator <u>Joy Powell, R. N.</u>	Support Services Coord. <u>Wilson Macenot</u>
Training Coordinator	Bookkeeper
Health Post Coord.	Statistician
MCH Services Coord.	Drivers and Guards
Others	Others

APPENDIX H

AUXILLIARY NURSE QUESTIONNAIRE NAME _____ DATE _____

Earliest age for DTP-polio vaccination? _____

" " " measles & BCG injections _____ & _____

Minimum interval between vaccinations? _____

BCG dosage for under-ones? others _____ & _____

What is dosage for DTP? OPV, measles _____ & _____ & _____

Which target vaccines can be frozen? _____

" " " cannot be frozen? _____

What target vaccines are fragile to light? _____

Why must remaining vaccines that have been opened be discarded
the end of the vaccination session?

What is the target group for tetanus toxoid? _____

How long must needles and syringes be boiled to ensu
sterilization? _____

What are three important signs of dehydration? _____

When should a child with diarrhea be referred to a hospital? _____

What is vitamin-A dosage and treatment schedule for children

What is vitamin-A dosage and treatment schedlule for mothers

What action do you take after weighing a baby _____

List three acceptable methods employed for birth spacing

APPENDIX I

ANIMATOR QUESTIONNAIRE NAME _____ DATE _____

What is your chief function in the community? _____

Do you live in the zone where you work & why _____

How do you determine if a village health committee is functioning properly? _____

What is the earliest age a child can receive OPV _____,
DTP _____, BCG _____, and measles vacc _____

What is the minimum interval between vaccinations _____

What is the maximum interval between DTP-polio vaccinations _____

At what age should a child start receiving vitamin-A _____

At what intervals should a child receive vitamin-A _____

Until what age should a child receive vitamin-A _____

When should women receive vitamin-A _____

How often should a woman receive vitamin-A _____

What are the three main food groups _____

What advice do you give parents when their child has diarrhea

What advice do you give parents when their child is malnourished

Why do you encourage couples to use contraception methods

Why do you encourage pregnant women to go to pre-natal clinics

Why do you encourage mothers of newborns to go to post-natal clinics _____

HEALTH PROMOTOR QUESTIONNAIRE
KESYONE POU PROMOTE

NAME _____
NON _____

DATE _____
DAT _____

How would you perceive your role in the community _____
Ki rol you promote gingnin nan you kominote _____

What is the minimum interval between vaccinations _____
Ki pi piti interval ki gingnin ant de doz vaksin _____

What is the earliest age a child can receive OPV _____
A ki laj ou kab komanse bay you ti bebe vaksin polio _____

DPT _____
DiTeCoq _____

BCG _____
BCG _____

Measles _____
Roujol _____

What is the maximum interval between DPT/POLIO vaccinations? _____
Ki pi plis tan interval ki gingnin ant doz vaksin DiTeCoq/Polio _____

At what age should a child first receive vitamin A _____
A ki laj you ti moun kab resevoua premie doz vitamin A _____

At what intervals should a child receive vitamin A _____
Chak konbyen tan you ti moune ka resevoua vitamin A _____

When should a woman receive vitamin A _____
Ki le you fanm doue resevoua vitamin A _____

How often should a woman receive vitamin A _____
Chak konbyen tan you fanm doue resevoua vitamin A _____

What foods do mothers need to add to the diet for children to grow
Ki mange manman doue ajoute nan mange pou fe ti moune grandi byen _____

What advice do you give parents when their child has diarrhea
Ki konsey ou bay paran le ti moune yo gin diare _____

What advice do you give parents when their child is loosing weight
Ki konsey ou bay paran le ti moune yo ap pedi poi _____

What do think is the best definition of family planning
Kisa planning ye dapre ou minm _____

What are the benefits for the child when the parents practice family planning?

Ki avantaj ou ti moun ginnin le paran-l fe planning


Why do you encourage pregnant women to go to pre-natal clinics
Pouki sa ou doue ankouraje you fanm ansint pou al suiv nan klinik fanm ansint

Why do you encourage mothers of newborns to go to post-natal clinics
Pouki sa ou doue ankouraje fanm ki fek akouché pou ale nan klinik postnatal

How do you make ORS?
Ki jan ou kon prepare serom oral

When should you begin giving ORS to a child with diarrhea
Le you ti moun ginn diare ki le ou doue komanse ba li serom oral

What do you tell a mother when the growth line looks this?
Ki sa ou di you manman le ou oue Chemin la sante pitit li konsa



What advice do you give to TBAs?
Ki konsey ou kapab bay Matrone yo

Why should children be vaccinated
Pouki sa tout ti moun doue vaksinin

What is a vaccine
Kisa vaksin ye

MEBSH Community Health/Child Survival

HEALTH COMMITTEE MEMBER QUESTIONNAIRE

NAME _____ DATE _____ Zone _____
 NON _____ DAT _____

How many times have you met during the past six months? _____
 Nan denie 6 moua ki sot pase laa Konbyen foua Komite a te reyni

Have you identified any health problems and what have you done about it?

Ki problem sante nou te idantifie nan zon nou an e ki sa nou te fe pou rezoud problem sa yo

How many projects have you identified? _____
 Kombyen proje komite a te fe pou zon

How many projects have you realized? _____
 Konbyen proje komite a te realize

What have you done as a group for the good of your community?
 Ki aksyon an group komite a te pran pou avansman kominote a

Have you ever had a project fail? _____ Why did it fail?
 Eske komite a te jam gin you proje ki komanse epi ki kraze?
 Poukisa sa pat mache?

How do you supervise your health promotor? _____
 Ki jan komite a fe sipevizyon promote yo

How do you supervise your TBA? _____
 Ki jan ou fe sipevizyon Matrone yo

What do you do to improve the attendance at the rally posts?
Ki sa komite a fe pou fe plis moune vini nan pos rasanbleman

What works well at your rally post?
Ki sa ki mache byen nan pos ou yo?

What should be improved at your rally post?
Kisa ki ta doue fet pi byen nan pos yo

What can the health committee do to get more women and children vaccinated in your community?
Kisa Komite a fe pou kapab gingnin plis fanm ak plis ti moune ki vaksinin nankominote a?

JULY 1991
CHILD SURVIVAL PROJECT
FINAL EVALUATION

Name of Women
5 - 49 years

COMMUNITY HEALTH PROGRAM
MEDICAL DIVISION
MESH

Age

Localité

Date TT 1

Date TT 2

Date Rappel

Received Vit A
Post Partum

Date of Birth
last child
under 2 YO

Number of dose
Vit A for child

of times
child weighed

More than one
visit required
to be immunized

How many visits
are required?

Do you continue
to feed your child
when he has diarrhea?

Do you continue
to give him
liquid when he
has diarrhea?

Do you know how
to prepare
ORS packets?

Do you know
about birth sp.

Do you
feel welcomed
at the rallye
Port?

Is the time to
and at the R.P. wort;
Sufficient
advance notice for RE

Vaccinate Your Children

Hear some news, friend, vaccinate your children,
BCG, DTP, Polio and Measles.

As soon as the child is born give him/her BCG. Polio, DTP - three doses,

Run to a center, vaccinate your children.

First dose, one and a half months, second dose, two and a half months, third dose, three and a half months.

You will wait till he is nine months to give measles.

Leonel Estin - LaBich

Wash Our Hands

1. I am happy, I have good health (2x)

To stay in good health we need to wash our hands
Remember well, we need to wash our hands (2x)

2. Wash our hands after we use the latrine (2x)

All these germs are a big source of sickness

Soap up well and we will kill them (2x)

3. Wash our hands, remember the children too (2x)

Before we give them a little bread or fruit

If their hands are dirty, they will get sick. (2x)

4. Wash our hands when we cook food (2x)

When we enter the kitchen

Wash with soap and clean water. (2x)

5. Wash our hands when we come from the garden (2x)

All the dirt in the garden is full of worm eggs

Oh friends, we do not want to eat them.

6. Wash our hands before we eat (2x)

Help the children wash theirs too,

Every time they eat, several times a day. (2x)

VACCINATION SONG

Chorus: Parents don't be negligent
Let's give our children their vaccinations
Parents don't be negligent
Let's give our children vaccinations

1. A lot of children die
Because their parents are negligent
Some diseases are spreading
Let's hurry up and get our children vaccinated
2. Children need 3 doses of the vaccines
DPT & Polio
To protect them
Against these diseases
3. There are other vaccinations we can receive
For TB there's BCG vaccine
For pregnant women there's tetanus vaccines
Lastly there's a vaccine for measles

La Jeune: L'Eglise missionnaire

TETANUS SONG

1. Oh my, I didn't know what to do
My children died with tetanus
There was no way to save my babies
I should have been vaccinated when I was pregnant
2. Next time I'll hurry to be vaccinated
I won't wait until it's too late
My other children will receive DPT vaccines
To protect them against tetanus
3. My granny midwife when you care for
The umbilical cord
Don't apply sawdust charcoal, nutmeg or things like wax
Down with tetanus!

Repeat (2) On my the next time I have a baby
I'll prepare everything I need ahead of time
I'll find a granny midwife who has been trained properly
A new razor blade and all the preparations

Mme Jay Weaver

1. Don't be negligent if you please
When it comes to this disease
Seek the road that leads to the dispensary
To find out what you have
3 weeks you're coughing non stop
You don't seek the road to the doctor
There are people who are foolish
In trying to hide the disease Tuberculosis
Sometimes they die
It's Tuberculosis that kills them
2. If you should get tuberculosis
There's medicine that can cure you
You don't have to be ashamed
When the doctor says you have tuberculosis
There's medicine to destroy this microorganism
We can have power over it
Don't be negligent
It's not profitable for you
Seek the road that leads to the doctor
In order to know what you should do

Chorus: Up with health Repeat 4 times
 Down with disease

3. Education means give advice
Show people the road that leads to the doctor
Against tuberculosis which is killing Haitians
Especially when he finds the TB germ in your body
That's when you can die
Don't be negligent
When you find you are coughing all the time
Seek the road to the dispensary
In order to know what you should do
Don't be negligent
When you see you are coughing all the time
Health is precious
Don't be ashamed to go to the dispensary

Jeff Nault and Wesner Belgarde

AIDS SONG

- I. Aids is a disease which leads to death
We should be more careful in order to have victory
Be careful, be careful, to be victorious
- II. We should be faithful - no more than one wife
Avoid more than one partner that way we can have security
Guard yourself, guard yourself - that way we can have security
- III. We can get AIDS from contaminated syringes
Take shots in a good way, to have more assurance
Good health, good health - it's the best gift we have

Evelt Mentor

Oral Rehydration Serum Song

1. When our children have diarrhea, have diarrhea, have diarrhea,
When our children have diarrhea, we should give them serum.

We should give them serum, we should give them serum,
When our children have diarrhea we should give them serum.

2. Make serum with sugar, salt & water, sugar, salt & water, sugar,
salt & water,
Make serum with sugar, salt & water, replace the fluids that they
lose.

Replace the fluids that they lose, replace the fluids that they
lose,
Make serum with sugar, salt & water, replace the fluids that they
lose.

3. Fill a cola bottle with clean water, with clean water, ~~with~~
clean water,
Fill a cola bottle with clean water, add 1 pinch of salt.

Add 1 pinch of salt, add 1 pinch of salt,
Fill a cola bottle with clean water, add 1 pinch of salt.

4. Taste it to see if it is not saltier, if it is not saltier, if
it is not saltier,
Taste it to see if it is not saltier than your tears.

Than your tears, than your tears,
Taste it to see if it is not saltier than your tears.

5. Finally, add a bottlecap full of sugar, a bottlecap full of
sugar, a bottlecap full of sugar,
Finally, add a bottlecap full of sugar, shake the serum well.

Shake the serum well, shake the serum well,
Finally, add a bottlecap full of sugar, shake the serum well.

6. Give serum with a spoon and cup, a spoon and cup, a spoon and
cup,
Give serum with a spoon and cup as long as he/she can drink it.

As long as he/she can drink it, as long as he/she can drink it,
Give serum with a spoon and cup as long as he/she can drink it.

BREASTMILK SONG

1. If you want your baby to grow
You need to give him natural milk (mother's milk)
Give the child breastmilk
Until he is two years old
Breastmilk is the best milk
Bottles are a sacrifice
2. If you want your baby to grow
You need to give him natural milk (mother's milk)
Give the child breastmilk
Feed him a balanced diet
Breastmilk is the best milk
Bottles are a sacrifice
3. Oh what a beautiful thing
When your baby grows and develops well
Oh what a beautiful thing
When your baby grows and develops well
Oh what a beautiful thing
When your baby grows and develops well

Planning Song

To not have children one after the other (too often), there are
good methods you can use.
That doesn't mean that you won't ever have children again,
But it is so you can have children when you want them,
So you can have more energy and can rest. (2x)

When someone follows planning, it is a good idea she/he has,
Because children need to be well taken care of,
And so you can have time to give them an education,
With these ideas, all the older people will be very happy. (2x)

There are several planning methods a person can use,
There are tubals, condomms and pills,
Vaginal tablets if you would like to use them,
With all these things, you will have a chance to rest. (2x)

Beth Weaver

22 NE
DISTRICT

COMMUNE

SECTEUR

LOCALITE _____

INSTITUT

POSTE RAS* _____

~~EQ CHEVAL*~~ _____

~~EQ MOBILE*~~ _____

AUTRE _____

(preciser)

POP _____ X 3.5 _____ ENFANTS < 1 AN + 12 = _____ ENFANTS CIBLE PAR MO

AUTRE

AUTRE

AUTRE

VACC ENF. ROUG.	0 - 11 MOIS ✓				12 - 23 MOIS ↓				24 MOIS ET + ↓				TOTAL
	INST	P.R.	EQ CNPP	J.C.	INST	P.R.	EQ CNPP	J.C.	INST	P.R.	EQ CNPP	J.C.	
BCG													
POL-0													
POL-1													
POL-2													
POL-3													
POL-R													
DTP-1													
DTP-2													
DTP-3													
DTP-R													

VACC ANTI-TETANIQUE	FEMMES 15 - 49 ANS				AUTRE				TOTAL
	INST	P.R.	EQ CNPP	J.C.	INST	P.R.	EQ CNPP	J.C.	
TETANOS TOXOID - 1									
TETANOS TOXOID - 2									
TETANOS TOXOID - R									

NBRE DES F. ENCEINTE EXAMINE PRE-N _____ POST-N _____

NBRE D'ENFANTS PESÉS _____ UNDER WEIGHT _____ RECUPERES _____

NBRE D'ENFANTS AVEC DIARRHEE _____ TRAITS TRO _____ DESILATES _____
VOIR VERSO SVP

APPENDIX U

MATERIEL	QTE RESTANTE DU MOIS PRECEDENT	QTE RECUE AU COURS DU MOIS	QTE UTILISE AU COURS DU MOIS	QTE RESTANTE A LA FIN DU MOIS
ROUGEOLE	DOSES			
BCG	DOSES			
POLIO	DOSES			
DTE	DOSES			
TET. TOXOID	DOSES			
CART VAC ENF				
CART VAC FEM				
SERINGUE ICC				
SER, 2CC + AIG				
ALIGUILLE 26G				
SRO	SACHETS			
VITAMINE A	COMPRIMES			
FER FOLATE	COMPRIMES			
BOURBONNE GAZ				

DECLARATIONS MENSUELLES DES CAS

GROUPE D'AGE	ROUGEOLE			COQUELUCHE			TETANOS NEO-N*		
	VACC	N/VA	INCO	VACC	N/VA	INCO	VACC	N/VA	INCO
0 - 11 MOIS									
12 - 23 MOIS									
24 - 35 MOIS									
36 - 47 MOIS									
48 MOIS ET +									
INCONNU									
TOTAL									

CHAINE DU FROID

NBRE DE REFRIGE. _____

NBRE EN PANNE _____

NBRE EN ETAT _____

SUPERVISIONS RECUES _____

NBRE RAPPORTS ATTENDUS _____ NBRE RECUS _____

POSTE (Commune) (District) ZONE (Commune) (District) ZONE

ETAT VACCINAL DE LA MERE, PAS DE L'ENFANT

APPENDIX V -- DOCUMENTS READ

The following documents were read for the evaluation:

- Cooperative Agreement No. OTR-0536-A-00-7224-00 & Amendments
- WRC/MEBSH Haiti CS Project Detailed Implementation Plan
- WRC/MEBSH Haiti CS Project FY 88 Annual Report
- WRC/MEBSH Haiti CS Project Mid-term Evaluation Report
- WRC/MEBSH Haiti CS Project Third Annual Report
- CS Training Assessment and Strategy, 1988, P. Chaponniere
- CS Training and Supervision Activities, 1989, Chaponniere
- Technical review of CS/MEBSH DIP
- Numerous administrative documents, files, correspondence, records and reports